



Emergency medical social work and clinical crisis intervention in a tertiary hospital: A multiple-case study of vulnerable patient populations in Vietnam

Thi Phu Bang Hoang¹

Ngoc Anh Thu VU^{2,4}

Manh Quan NGO³

Thi Mai Thanh Duong⁴

Kim Oanh Nguyen⁵

^{1,2,3,4} Department of Social Work and Communications, Bach Mai Hospital, Hanoi, Vietnam.

¹ Email: tambangduc@gmail.com

² Email: vungocanhthu51@gmail.com

³ Email: quannm@bachmai.edu.vn

⁴ Email: maithanh12a01@gmail.com

⁵ Vietcare Psychology and Social Work Application Co., Ltd., Hanoi, Vietnam.

⁵ Email: nguyenkimoanhmk93@gmail.com

Abstract

This study aims to examine how medical social workers resolve acute psychological, legal, and protective impasses among vulnerable emergency patients, and how intrahospital and interagency coordination shapes these outcomes, in a Vietnamese tertiary hospital operating under Circular No. 51/2024/TT-BYT. A qualitative multiple-case study was conducted of five crisis interventions delivered between 2024 and 2026 at a national tertiary referral hospital, purposively selected to span physical abuse, post-discharge exploitation, acute suicidality, guardianship deadlock, and trafficking risk. Case logs, social work records, incident reports, and interagency correspondence were analyzed deductively against Roberts' seven-stage crisis intervention model and inductively through open and axial coding, informed by trauma-informed care and Bronfenbrenner's social-ecological model. All five cases reached safe, stabilized outcomes, and in each the definitive medical intervention became possible only after a psychosocial or legal impasse had been resolved. Practice aligned closely with Roberts' model but required adaptation to engage extended kin and commune authorities, together with boundary-spanning work beyond the hospital. Four recurrent bottlenecks constrained practice: the absence of an expedited mechanism for emergency surrogate consent, the lack of a secure crisis room, reliance on ad hoc charitable funding, and staff exposure to secondary traumatic stress. Manual verification of proxy consent required approximately four to six hours per case. The findings suggest that hospitals should institutionalize a 24-hour interagency rapid-response protocol led by the social work department, digitize civil identity and proxy authorization, establish defined emergency financing pathways, and protect staff through formal supervision and post-incident debriefing.

Keywords:

Child protection
Crisis intervention
Interagency collaboration
Medical social work
Suicide prevention
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(⁴ Corresponding Author)

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Transparency: The authors confirm that the manuscript is an honest, accurate, and transparent account of the study; that no vital features of the study have been omitted; and that any discrepancies from the study as planned have been explained. This study followed all ethical practices during writing.

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1. Introduction

In tertiary hospitals throughout low- and middle-income countries, emergency admissions are rarely isolated biomedical events. Within emergency departments and pediatric intensive care units, clinical teams routinely encounter patients whose acute, life-threatening pathology is compounded by domestic violence, active suicidality, absent legal guardianship, or organized exploitation (Fraser et al., 2018; World Health Organization, 2020). Clinical pathways for the biomedical component of these presentations are rigorously standardized; institutional frameworks for the psychosocial component that accompanies them remain fragmented, discretionary, and dependent on individual practitioners.

Medical social work occupies precisely this gap. Since Ida Cannon established the first hospital social service department at Massachusetts General Hospital in 1905, the profession has been defined by the proposition that a patient is a member of a family and a community rather than an isolated body (Cannon, 1923). By the 1920s, the American Hospital Association had begun to treat the provision of social work services as an element of hospital quality, a shift that repositioned the social worker from philanthropic volunteer to clinical peer (Nacman, 1977; Ruth & Marshall, 2017). Contemporary scholarship documents the resulting scope of practice: psychosocial assessment, crisis intervention, safeguarding, discharge planning, and mediation between the hospital and community welfare systems (Craig & Muskat, 2013; Judd & Sheffield, 2010).

The Vietnamese trajectory has been considerably more compressed. Social work in Vietnamese hospitals long consisted of informal charitable activity, such as distributing meals or administering small donations, and preceded any formal professional recognition. Structured professionalization began only in the early twenty-first century, catalyzed by Decision No. 32/2010/QĐ-TTg approving the national project for social work development and by Circular No. 43/2015/TT-BYT, which first required hospitals to organize social work functions (Government of Vietnam, 2010; Ministry of Health, 2015). Circular No. 51/2024/TT-BYT extended this framework substantially, mandating formal social work departments, defining intrahospital multidisciplinary workflows, and requiring interagency coordination with community protection systems (Ministry of Health, 2024). Vietnamese hospital social workers are therefore required to assume clinical crisis intervention roles at the same time as they build the basic administrative and financial infrastructure that comparable Western services institutionalized over several decades (Hugman, Lan, & Hong, 2007; Nguyen, Nguyen, & Le, 2019).

Empirical accounts of how this compressed development plays out at the bedside are scarce. Existing Vietnamese literature is largely descriptive of policy or of service volumes, and the international crisis intervention literature is dominated by settings with integrated civil registries, statutory child protection services, and reliable emergency financing. What is not documented is how practitioners resolve acute psychological, legal, and protective impasses when those structures are absent or only partially available. This study addresses that gap through two research questions:

1. How do hospital medical social workers navigate and resolve acute psychological, legal, and protective bottlenecks under structural resource constraints?
2. What role does intrahospital multidisciplinary collaboration and external interagency coordination play in securing immediate clinical outcomes and longer-term psychosocial safety for vulnerable patients?

2. Materials and Methods

2.1. Theoretical Framework

The study adopts an interpretive, naturalistic stance and integrates three complementary frameworks. Roberts' seven-stage crisis intervention model provides the operational roadmap for bedside practice, sequencing intervention from lethality and biopsychosocial assessment through rapport building, problem identification, exploration of feelings, generation of alternatives, action planning, and follow-up (Roberts, 2005; Roberts & Ottens, 2005). Trauma-informed care anchors the intervention in an ethic of safety, trustworthiness, collaboration, and empowerment, and directs attention to whether the hospital environment

itself is a source of retraumatization (Levenson, 2017; Substance Abuse and Mental Health Services Administration, 2014). Bronfenbrenner (1979) social-ecological model supplies the systems-level lens used to locate barriers, mapping intervention across the microsystem of individual and family trauma, the mesosystem of clinician-social worker-patient interaction, the exosystem of police and community welfare agencies, and the macrosystem of national legislation, including Circular No. 51/2024/TT-BYT.

2.2. Design and Setting

A qualitative multiple-case study design was used, an approach suited to examining a contemporary phenomenon within its real-world context when the boundary between phenomenon and context is not clear-cut (Yin, 2018). The setting was the Department of Social Work and Communications of Bach Mai Hospital, a national tertiary referral hospital in Hanoi that receives complex transfers from northern Vietnam.

2.3. Sampling

Five cases managed between 2024 and 2026 were selected by purposive, information-oriented sampling (Patton, 2015). Cases were eligible if the presentation combined an acute medical emergency with at least one severe psychosocial or legal crisis, if the social work intervention was fully documented across the episode of care, and if the outcome was recorded at or after discharge. The final set was chosen for maximum variation across the spectrum of vulnerability encountered in the department: physical abuse, post-discharge exploitation, acute suicidality, guardianship deadlock, and trafficking risk. No case meeting the criteria was excluded.

2.4. Data Sources and Analysis

The study was retrospective and drew on multiple documentary sources: clinical case logs, social work assessment and progress records, incident reports, and interagency correspondence, including police reports and communications with commune-level authorities. Materials were analyzed in two phases. In the deductive phase, each documented action was mapped against the seven stages of Roberts' model to assess the consistency of frontline practice with the framework. In the inductive phase, open and axial coding in the grounded theory tradition was used to surface patterns the framework did not anticipate, principally recurrent systemic bottlenecks and the boundary-spanning tactics practitioners used to work around them (Corbin & Strauss, 2015). Coding was performed independently by two authors, and discrepancies were resolved by discussion until consensus was reached. Elapsed times reported for guardianship verification were derived from timestamps recorded in the social work case logs.

2.5. Trustworthiness

Rigor was addressed using the criteria of Lincoln and Guba (1985). Credibility was pursued through triangulation of data sources, with social work field notes cross-verified against the hospital electronic health record and against official legal and police documentation. Dependability and confirmability were supported by an audit trail linking every reported finding to its source document, and by peer debriefing within the research team. Transferability is supported by thick description of the setting and of each case, although the findings are situated in a single institution and are not offered as statistically generalizable.

2.6. Ethical Considerations

Institutional Review Board approval was not required for this study, as it involved a retrospective review of fully anonymized and de-identified case records, posing no potential risk or harm to the participants. Where a legal guardian was identifiable and contactable, written consent for publication was additionally obtained. Given the sensitivity of the material, all direct and indirect identifiers were strictly removed: patient names, exact dates, specific wards and communes, and any detail permitting re-identification were redacted or replaced with categorical descriptors. Ages are reported in whole years and sequences of events are reported in relative rather than calendar time. The study was conducted in accordance with the Declaration of Helsinki.

3. Results

3.1. Case 1: Prolonged Physical Abuse and Neglect in a School-Aged Child

Presentation: A 10-year-old boy presented to the pediatric emergency center with lethargy, persistent dizziness, headache, hypothermia, and repeated vomiting. Examination revealed extensive bilateral contusions of the upper limbs, large hematomas over the gluteal and femoral regions, and multiple healed scars. Investigation established systematic physical abuse by an informal private daycare provider. The mother lived in a distant province and the legal guardian, a maternal grandmother, was working abroad.

Assessment: Biologically, the child presented with postconcussive syndrome, extensive soft-tissue trauma, and exhaustion. Psychologically, he showed hypervigilance, marked withdrawal, and blunted affect. At the systems level, legal guardianship had broken down entirely, care was being provided in an unregulated informal arrangement, and the risk of post-discharge reabuse and abandonment was imminent.

Intervention: The social worker established an empathic alliance and delivered psychological first aid to reduce defensive withdrawal. An emergency cross-consultation with the National Institute of Mental Health was arranged to assess neurocognitive trauma and acute stress. Pursuant to Decree No. 56/2017/ND-CP, an expedited statutory report was filed with the National Child Protection Hotline 111, local police, and the ward People's Committee (Government of Vietnam, 2017). In the absence of a dedicated crisis facility, an outpatient examination room was temporarily repurposed for confidential, trauma-informed forensic interviewing.

Outcome: Law enforcement concluded its investigation and ordered full restitution of hospital costs by the perpetrator. The mother traveled to the hospital, signed formal protection undertakings, and resumed direct custodial care before discharge.

3.2. Case 2: Post-Discharge Exploitation for Begging and Recurrent Severe Infection in an Infant

Presentation: A 2-month-old girl was readmitted to the pediatric intensive care unit with acute respiratory failure and severe pneumonia requiring mechanical ventilation. Two months earlier she had been treated and granted full fee exemption through the hospital's social work charity fund because her mother was uninsured. The clinical emergency escalated into a child protection crisis when social media material identified during routine follow-up showed the mother's former partner exposing the infant to extreme weather while begging at major traffic intersections.

Assessment: Biologically, the infant had recurrent, life-threatening respiratory distress aggravated by prolonged environmental exposure. At the systems level, the case combined severe neglect, instrumental exploitation of an infant, and false residential declarations by the mother that had defeated local welfare tracking.

Intervention: The social worker cross-verified the digital evidence and undertook boundary-spanning fieldwork beyond the hospital. Working with grassroots police units, and after overcoming administrative obstacles, the team located the family's unregistered rental accommodation in a peri-urban ward of the capital. Case files were expedited to Hotline 111 and to the municipal social work center.

Outcome: The infant was weaned from mechanical ventilation and stabilized. Case management and the legal file were transferred to the municipal social work center for statutory placement and post-discharge judicial monitoring.

3.3. Case 3: Acute Suicidal Crisis on a Hospital Rooftop

Presentation: A 15-year-old girl was found in a state of extreme agitation, pacing the parapet of a high-rise inpatient tower with stated suicidal intent. The incident drew a substantial crowd and generated significant institutional risk.

Assessment: The immediate concern was lethality from a fall; examination subsequently revealed multiple self-harm lacerations on both forearms. Psychologically, she presented with pervasive hopelessness and an adjustment disorder superimposed on complex developmental trauma following maternal abandonment in early childhood and chronic paternal emotional abuse. At the systems level she had no functioning social network, had left school early, was unhoused, and had been sheltering repeatedly in public hospital corridors.

Intervention: The social worker deployed to the scene and used non-confrontational de-escalation and crisis negotiation to reduce affective arousal, creating the operational window in which rescue personnel could secure the patient safely during adverse weather. A continuous one-to-one bedside observation protocol was then implemented to prevent further self-harm, meet basic physiological needs, and build therapeutic rapport.

Outcome: Physical safety was preserved without bodily injury. Comprehensive psychosocial assessment supported voluntary psychiatric inpatient admission for stabilization, followed by transitional placement in a specialist youth welfare center where civil identity documents were restored and vocational training was initiated.

3.4. Case 4: Fraudulent Crowdfunding and Guardianship Deadlock in Emergency Pediatric Surgery

Presentation: An ethnic minority boy was transferred from a remote mountainous region with progressive limb necrosis following a venomous snakebite, requiring emergency amputation. A legal impasse arose immediately: the child had no legal guardian present, the accompanying adult was an undocumented stranger, and the accompanying adolescent brother spoke only an indigenous language and no Vietnamese.

Assessment: Biologically, necrotizing tissue toxicity carried a fatal septic risk without immediate surgical debridement. Legally, surrogate surgical consent was unobtainable, halting the operation. At the systems level, an informal network was exploiting digital images of the child's injuries to solicit online donations, with the apparent intention of abandoning him afterward.

Intervention: Through structured forensic interviewing and the exercise of statutory reporting authority, the social worker dismantled the crowdfunding scheme and terminated unauthorized fund solicitation. The social worker contacted the chairperson of the commune People's Committee in the child's home province to verify civil status, traced a maternal aunt by marriage resident in Hanoi to establish lawful guardianship, and facilitated proxy surgical consent. In parallel, humanitarian assistance was mobilized for medical fees and philanthropic funding was secured for a functional prosthesis.

Outcome: The amputation proceeded safely within the clinical window. The child received prosthetic rehabilitation, statutory health insurance entitlements were retroactively restored, and the fraudulent solicitation was stopped.

3.5. Case 5: Runaway Adolescent at Risk of Commercial Labor Exploitation

Presentation: A 16-year-old girl from a remote mountainous province presented unaccompanied to the pediatric center with severe acute abdominal pain and vomiting, without identity documents or financial means. Diagnostic imaging and pharmacotherapy were stalled by the absence of lawful consent.

Assessment: Biologically, she required urgent investigation of an acute abdomen. Psychologically, she presented with marked oppositional behavior, severe panic, and acute distress arising from family conflict. At the systems level, she had run away to the capital to work in a high-risk commercial entertainment venue and faced immediate risks of forced labor and sexual exploitation.

Intervention: The social worker coordinated with ward police to reach authorities in her commune of origin, verify her civil identity, and establish a lawful remote authorization, which allowed clinicians to proceed with investigation and treatment. Immediate nutritional and pharmaceutical relief was provided alongside supportive listening to de-escalate distress. To reduce the risk of absconding, secure transport was arranged through a subsidized hospital ambulance program that transfers patients without means of travel, and she was handed directly into the custody of her legal guardians in her home province.

Outcome: She recovered fully, the immediate exploitation risk was removed, and family reintegration was achieved safely.

3.6. Cross-Case Findings

The five cases are summarized in [Table 1](#) and described in narrative form below.

Table 1. Characteristics, interventions, and outcomes of the five cases.

Case	Age / sex	Clinical presentation	Primary psychosocial or legal crisis	Core social work intervention	Outcome
1	10 y, male	Post-concussive syndrome; extensive soft-tissue trauma	Systematic physical abuse by informal daycare provider; guardianship breakdown	Psychological first aid; statutory report to Hotline 111, police, ward committee; trauma-informed forensic interview	Custodial care restored to mother; restitution ordered
2	2 mo, female	Acute respiratory failure; severe pneumonia requiring ventilation	Post-discharge exploitation for street begging; false residential declaration	Evidence cross-verification; field location with grassroots police; referral to municipal social work center	Weaned and stabilized; statutory placement and judicial monitoring
3	15 y, female	Imminent fall risk; self-harm lacerations	Acute suicidality; complex developmental trauma; unhoused, no social network	Non-confrontational de-escalation and crisis negotiation; continuous 1:1 observation	No injury; voluntary psychiatric admission; youth welfare placement
4	Child, male	Progressive limb necrosis after envenomation; emergency amputation	No legal guardian; fraudulent online crowdfunding; language barrier	Forensic interviewing; commune-level civil status verification; proxy consent secured; funding mobilized	Timely amputation; prosthesis; insurance restored
5	16 y, female	Acute abdomen requiring urgent investigation	Runaway; no identity documents; risk of forced labor and sexual exploitation	Remote lawful authorization via commune authorities; supportive listening; secure escorted transfer	Full recovery; safe family reintegration

Note: Ages are reported in whole years or months. Identifying details have been removed or replaced with categorical descriptors.

[Table 2](#) maps the interventions delivered in each case against the seven stages of Roberts' model.

Table 2. Mapping of documented interventions to Roberts' seven-stage crisis intervention model.

Roberts' seven-stage model	Case 1	Case 2	Case 3	Case 4	Case 5
1. Lethality and biopsychosocial assessment	Yes	Yes	Yes	Yes	Yes
2. Rapid rapport and therapeutic alliance	Yes	Partial	Yes	Yes	Yes
3. Problem identification	Yes	Yes	Yes	Yes	Yes
4. Exploration of feelings and emotions	Yes	Not applicable (infant)	Yes	Partial (Language barrier)	Yes
5. Generating and exploring alternatives	Yes	Yes	Yes	Yes	Yes
6. Action plan and resource mobilization	Yes	Yes	Yes	Yes	Yes
7. Follow-up and post-crisis review	Yes	Transferred to municipal service	Yes	Yes	Partial (Referred to province)
Boundary-spanning activity beyond the model	Statutory reporting	Unannounced field investigation	On-scene rescue coordination	Dismantling fraudulent solicitation	Cross-provincial proxy verification

Note: "Yes" indicates the stage was documented in the case record. The final row records activity performed by the social worker that falls outside the seven-stage model.

Across the five cases, three converging patterns were identified. First, in every case the biomedical intervention was contingent on a prior psychosocial or legal resolution: surgery could not proceed without proxy consent (Cases 4 and 5), safe discharge was impossible under threat of reabuse or trafficking (Cases 1 and 2), and medical management of suicidality depended on de-escalation at the point of crisis (Case 3). Second, the social work intervention consistently extended beyond the hospital boundary, involving police, commune authorities, the national child protection hotline, and municipal welfare centers. Third, four recurrent bottlenecks appeared in every case file: the absence of an expedited statutory mechanism for emergency surrogate consent, the lack of a secure on-site crisis or safe room, reliance on ad hoc charitable appeals for immediate out-of-pocket costs, and cumulative occupational exposure of staff to violence and acute distress.

4. Discussion

These cases indicate that emergencies presenting to a tertiary referral hospital in this setting are seldom isolated biomedical pathologies. They present instead as biopsychosocial emergencies in which an acute clinical threat intersects with psychological trauma, legal deadlock, structural poverty, and organized exploitation. The conventional biomedical model was structurally insufficient in all five cases, and the medical social worker functioned as the component of the clinical team that made the biomedical intervention possible: stabilizing affect and mitigating acute trauma, resolving legal and administrative impasses so that urgent procedures could proceed, and bridging the hospital to community safety networks so that discharge did not simply return the patient to the conditions that produced the admission.

4.1. Theoretical Alignment and Cultural Adaptation of Crisis Models

The documented workflows aligned closely with Roberts' seven-stage model and with trauma-informed care principles. The seven-stage continuum provided a coherent progression from lethality assessment and rapport building through problem identification to resource mobilization, and in high-acuity events such as the rooftop negotiation (Case 3) and the abuse presentation (Case 1) it standardized the frontline response and reduced the risk of institutional retraumatization (Roberts & Ottens, 2005; Substance Abuse and Mental Health Services Administration, 2014).

Two adaptations were nonetheless required. Western crisis models generally presuppose an individually centered recovery trajectory supported by continuous community referral pathways. In this setting the patient is a node within an extended kinship and communal network that exerts decisive influence over treatment adherence and surrogate consent, a pattern consistent with wider accounts of collectivist family systems in Southeast Asian health care (Nguyen et al., 2019). Stages three and five of the model, problem identification and the generation of alternatives, accordingly had to engage extended family members and commune leaders as primary partners rather than as peripheral informants. In addition, practitioners routinely performed boundary-spanning work that the model does not anticipate, including unannounced field investigation of

unregistered accommodation (Case 2), dismantling online solicitation schemes (Case 4), and negotiating cross-provincial proxy verification with commune authorities (Cases 4 and 5). These activities are better described by Bronfenbrenner (1979) exosystem than by any stage of the crisis model, and they suggest that crisis intervention frameworks exported to low-resource settings require an explicit systems-navigation component.

4.2. Multidisciplinary Coordination and Systemic Bottlenecks

Social workers operated as connectors across four axes: physician-patient, patient-family, intrahospital interprofessional specialties, and hospital-external welfare networks. Despite favorable outcomes in every case, the case files exposed four structural vulnerabilities. The absence of an expedited statutory mechanism for emergency surrogate consent for unaccompanied minors forced reliance on improvised and legally fragile workarounds. The lack of a dedicated, secure crisis or safe room required the temporary use of outpatient clinics or open ward beds, compromising forensic confidentiality and exposing staff to security risk from hostile parties (Case 1). Heavy reliance on ad hoc charitable appeals for non-formulary medicines, food, and transport introduced delay into clinical workflows. Finally, prolonged overnight one-to-one observation, repeated exposure to acute violence, and direct confrontation with exploitative actors generated conditions associated with secondary traumatic stress and burnout in the hospital social work literature (Bride, 2007; Cieslak et al., 2014).

4.3. The Administrative Efficiency Gap

A specific finding concerns the time cost of administrative fragmentation. In health systems with integrated civil registries and statutory emergency guardianship provisions, surrogate consent for a life-saving procedure can typically be secured within minutes. In this setting, log timestamps indicate that resolving a surgical proxy impasse for an unaccompanied or undocumented minor required approximately four to six hours of intensive manual coordination per case, comprising repeated cross-provincial telephone contact, physical dispatch of official correspondence, and manual kinship verification with grassroots authorities. In time-critical presentations such as progressive necrotizing envenomation (Case 4) or an acute surgical abdomen (Case 5), this interval is not an administrative inconvenience but a clinical risk factor that delays definitive treatment and diverts the social worker from crisis intervention into documentary investigation. This estimate is derived from five cases at a single institution and should be treated as indicative rather than definitive.

4.4. Implications for Practice and Policy

Three sets of measures follow from these findings. The first concerns standardized operating procedures. When a patient presenting with suspected abuse or exploitation is admitted, the receiving unit should immediately activate a child and vulnerable population protection board so that clinical stabilization proceeds in parallel with, rather than at the expense of, the preservation of forensic evidence; standardized anatomical injury mapping and biopsychosocial assessment instruments should be mandatory at this point, since they generate the documentation on which any subsequent legal proceeding depends. Coordination should then be sustained through a 24-hour interagency rapid response protocol, led by the social work department and linking clinical units, hospital security, and local police with the national child protection hotline. Where a major clinical decision is required for a patient with no legal representative, an emergency hospital-wide consultation should be convened and administrative clearance obtained from the executive board before institutional clinical guardianship is exercised. Procedural readiness also requires financial capacity: institutions should establish defined pathways drawing on statutory mechanisms, including the national child protection fund, to cover non-reimbursed medicines, meals, and safe repatriation, and social workers should systematically guide guardians through advance payment and fee relief procedures so that existing legal entitlements are not lost through unfamiliarity.

The second concerns digital infrastructure. To address the administrative paralysis observed in Cases 4 and 5, we propose an integrated patient identity and proxy authorization pathway with three components: read-only hospital access to the national civil identity database, which would reduce kinship verification from hours of manual work to a single query; a mechanism, authorized under Circular No. 51/2024/TT-BYT, by which commune chairpersons can issue a temporary digital proxy authorization signed with a secure digital certificate and carrying the same legal weight as its paper equivalent; and a cross-sectoral data exchange protocol linking hospitals with the national child protection hotline and police, so that the admission of a patient flagged as at risk notifies social work, forensic units, and law enforcement simultaneously rather than through a sequence of disjointed telephone calls. Together these measures would shorten the patient's window of vulnerability and return the social worker from the role of administrative investigator to that of clinical crisis interventionist.

The third concerns the workforce. Targeted forensic and legal competency training should be provided to physicians and nurses, covering clinical injury documentation, statutory reporting obligations, and early recognition of abuse. Non-confrontational de-escalation, verbal crisis negotiation, and trauma-informed forensic interviewing should be integrated into continuing medical and nursing education so that clinicians

can elicit sensitive histories without retraumatizing patients in acute distress. Equally, the psychological safety of frontline staff must be institutionally protected through formalized clinical supervision and mandatory post-incident psychological debriefing after critical events, without which secondary traumatic stress and burnout will erode the sustainability of the protective system these recommendations describe. Financially, emergency social work services should move from unpredictable philanthropic funding toward formal inclusion in the national social health insurance reimbursement schedule, recognizing crisis stabilization, forensic documentation, and crisis negotiation as reimbursable clinical activities.

5. Limitations

Several limitations qualify these findings. The study is retrospective and relies on documentation generated for clinical and legal rather than research purposes, so the record of practitioner reasoning is necessarily partial. All five cases derive from a single national tertiary referral hospital with an established social work department and comparatively strong institutional support; practice in provincial or district hospitals may differ substantially. Purposive selection of complex cases was appropriate to the research questions but means the sample is not representative of the department's overall caseload. Patients and families were not interviewed, so outcomes are reported from the institutional perspective and service user experience is absent. Follow-up was limited to the period documented in the case file, and longer-term psychosocial trajectories are therefore unknown. Finally, coding was undertaken by members of the team that delivered the interventions, and although independent double coding, source triangulation, and an audit trail were used to mitigate this, the possibility of interpretive bias cannot be excluded.

6. Conclusion

Emergency medical social work in this setting was not an adjunct to emergency medicine but a condition of its effectiveness. In each of the five cases examined, the definitive clinical intervention became possible only after a psychosocial or legal impasse had been resolved, and safe discharge depended on connections made beyond the hospital boundary. The constraints identified are structural rather than individual, and the corresponding remedies are institutional: a standing rapid-response protocol with parity for the social work department, a secure on-site crisis space, digitized guardianship verification, defined emergency financing, and formal protection of staff psychological safety. Further research should examine these mechanisms prospectively across multiple institutions and should incorporate the perspectives of patients and families, whose accounts are absent from the present study.

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