

What can we learn from the Singapore experience? First, management of dementia needs integrated, collaborative, and sustained efforts among all stakeholders to deliver holistic care. Cultural changes are needed to change the focus to prevention and early intervention.

Second, primary prevention is often neglected and a knowledge gap exists with regards to community services and resources. Collaborations between health-care professionals and community workers in the health and social sectors would extend community outreach and support. The general public's scarcity of knowledge and awareness of dementia needs to be addressed to avoid fear and stigmatisation. Public awareness campaigns should be developed to improve public and professional attitudes to people with dementia.

Finally, research on ageing should be a priority because evidence-based studies are required to support health policies and to identify barriers and facilitators of change. Longitudinal cohort studies will be important to establish causal associations between early psychosocial interventions and dementia.

The Singapore experience, including non-governmental organisations and private charitable organisations, is innovative and instructive. Early psychosocial inter-

ventions can reduce the incidence of dementia, improve elderly people's quality of life, reduce the disease burden on families and society, and ultimately help elderly people achieve what they all hope for in old age—prosperity (*fu*), fortune (*lu*) and longevity (*shou*).³

We believe that the Singapore early dementia prevention programme model can be replicated in other parts of the world, and especially in China with the similarities in the two countries' demographics and cultures.

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Mental health services: where do we go from here?

Investment in mental health services makes economic sense in both developed countries and in developing nations, such as South Africa.^{1,4} The next question is: what is the best way of delivering mental health care in different contexts?

After 50 years of deinstitutionalisation of mental health in Europe and North America, WHO has recommended this approach as a global policy. The process has many components, from restriction of the number of hospital beds, through the establishment of community-based mental health services, development of mental health services in general hospitals, integration of mental health services into primary health care, building of informal community mental health services, to promotion of self-care. This plan moves services from high-cost specialised psychiatric care to less costly community and self-care. WHO has warned, however,

that countries should learn from early experiences, in which failure to establish the various services before implementation of deinstitutionalisation led to increased problems of marginalisation, homelessness, and deterioration of psychiatric disorders in affected patients.⁵

Therefore, translation of research outcomes into policy frameworks for implementation and evaluation is imperative. Partnerships between all stakeholders need to be established and strengthened. Tomlinson and Lund analysed why global mental health does not receive the attention it deserves and highlighted an absence of civil society advocacy for change as a weakness.⁶ Fortunately, the number of organisations driven by mental health care users is increasing and these have a key role in service development, as described in the Driving Change Report compiled by

the McPin Foundation. The report described such organisations to be: “Driven by a values-based strategy that places lived experience at the core of developing policy or delivering support, a perspective that is vital but often ignored, they offer the mental health sector multiple ways of addressing complex problems and empower individuals on a recovery journey.”⁷

Many important players are involved in advancing mental health, including mental health professionals, researchers, policy makers, civil society organisations, governments, the media, and, most crucially, mental health care users and their representative organisations. All these groups should engage in a collaborative approach to service development and acknowledge the validity of each other’s roles. For decades, mental health care users have been excluded from this process and perceived as an invalid component. This is especially true in countries where high levels of stigma exist related to myths and misinformation, which creates the perception that people with mental health disorders are incapable of participating in their own lives.

Mental health care users have been shown to be instrumental in improving service delivery through a human rights approach and by affecting policies and legislation.⁸ Empowered individuals have the ability to contribute effectively to the drafting and review of related strategies, policies and legislation, and to minimise flaws in the system through knowledgeable input. In addition to a consultative role as to what adequate services should be like, mental health care users have proved to be valuable in being actively

involved in service delivery through community engagement to reduce stigma and discrimination that often result in people avoiding accessing mental health services.⁹

Stigma and discrimination are a major concern both in mental health service delivery and for people who require and acquire services. An example of an organisation driven by mental health care users that addresses the challenges and barriers experienced is the Gauteng Consumer Advocacy Movement (GCAM) in South Africa. GCAM believes that the cornerstone of a society free from stigma and discrimination is the universal right to life. Inclusion and autonomy should be added to this concept. Such a society is achieved by its members having access to accurate and evidence-based information, and each person taking ownership of their basic human rights and responsibilities. GCAM has developed communication strategies that use technology in the form of multimedia accessible on mobile phones and the performing arts as effective methods of education about mental disorders and human rights for mental health care users, mental health workers, and communities.

A concern that is often raised by service user representatives is the absence of progress on the ground. Despite huge input of expertise during deliberations at local and international meetings to discuss mental health, the outcomes are disappointing.

The implementation of a deinstitutionalisation programme as recommended by WHO provides an opportunity to improve care for millions of people with mental health problems. However, two major potential problems exist. First, providers must not see the cost reduction involved in deinstitutionalisation as an excuse to reduce budgets for mental health care services—the money should follow the service users into community-based care and rehabilitation and include programmes that facilitate recovery and empowerment that would lead to self-care. Second, the community should be prepared to accept the integration of mental health care users from institutions. Otherwise, people with mental disorders could oscillate between health-care services and the community, creating a “revolving door” syndrome. The goals for the next 10 years are therefore to hold providers accountable for maintaining budgets for mental health services and to transform communities into an encouraging environment, free from stigma and discrimination.



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