The Royal College of Psychiatrists and similar organisations may feel that it is not appropriate to become embroiled in the social and political factors that are often cited as the cause of violence, but such detachment should not interfere with unambiguous advocacy for human rights in all circumstances.

In this context, psychiatrists may also be able to contribute to scientific research on understanding the reasons behind violence against society, including gaining an understanding of the underlying ideological motivations. This is clearly of increasing importance if we are to prevent the development of a 'sick' society – one that is imbued with bitterness, resentment, revenge, aggression and violence. Political solutions alone, however sound, will never be fully effective unless attention is paid to helping individuals within society with their own emotional responses.

Tackling this problem energetically is important. 'Sick' societies provide an environment in which organised crime can develop and flourish. Drug-related crime and the illegal arms trade, for example, are particularly well known for the way in which they can undermine the authority of the state and provide funding for politically related violence. The Royal College of Psychiatrists and similar organisations may feel that it is not appropriate to become embroiled in the social and political factors that are often cited as the cause of violence, but such detachment should not interfere with unambiguous advocacy for human rights in all circumstances. Specifically, whatever the threat of violence, psychiatry and psychiatrists should remain focused on the needs of those who are mentally ill and should resist political pressure to treat as sick those individuals whose behaviour may be inconvenient to those in power. The Royal College of Psychiatrists can make a very positive contribution to those ideas by maintaining robust links with psychiatrists in other countries and by supporting them in difficult situations.

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THEMATIC PAPERS – INTRODUCTION

Dementia in low- and middle-income countries

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Dementia care places considerable financial burdens on families.… The idea that extended family care reduces this problem is misleading, and certainly does not apply to those families for whom survival depends on all family members working.

It is 100 years since Dr Alois Alzheimer, a German neurologist, observed changes in the brain that are now known to be the characteristic features of Alzheimer's disease, the commonest form of dementia. Until recently this condition was thought to occur only infrequently in low- and middle-income countries; now it has been realised that the prevalence is as high in these countries as in the rest of the world. Further, because of the rapidly increasing numbers of older people in low- and middle-income countries, they contain far more people with dementia: 16 million compared with 8 million in high-income nations. How can ways be found to provide adequate care for people with dementia in these countries when resources, both skilled manpower and finance, are so limited? The thematic papers that follow address this issue.

In their article 'Ageing and dementia in low- and middle-income countries', Martin Prince and Daisy Acosta point first to the degree to which the burden of disability in these countries, as elsewhere, falls disproportionately on older people, who are likely to suffer from multiple disorders. They describe the 10/66 Dementia Research Group, a remarkable collaborative venture that aims to develop standardised diagnostic procedures, undertake comparative prevalence studies and describe care arrangements and patterns of service development in low- and middle-income countries. The links between this group and Alzheimer's Disease International (itself the subject of an article in this issue under 'Associations and collaborations') provide a bridge with the voluntary sector that allows research findings to be rapidly disseminated and utilised to the benefit of the affected populations.

Dementia care places considerable financial burdens on families. Carers are often prevented from working because of the need to provide full-time care for their affected relative. The idea that extended family care reduces this problem is misleading and certainly does not apply to those families for whom survival depends on all family members working.

In the paper on dementia care in Latin America, Aquiles Salas and Raul Arizaga describe the situation in Venezuela, where few people receive adequate non-contributory benefits; most people over the age of 65 receive only US$35 a month. The problem is compounded by the fact that virtually all medical and day care services are privately provided. Under the

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aegis of the 10/66 Dementia Research Group a start is being made to train family carers. If it is to have an impact, this small initiative will need to generate a snowball effect. The situation described in Argentina appears to be marginally better, with slightly higher pensions and a significant contribution to the healthcare system made by public funds. Diagnostic neuroimaging and medication are available in Argentina but, clearly, many cannot afford them. Perhaps of greater significance in any case is the need for increased awareness of the condition, so that it can be accurately diagnosed and appropriate nursing and social care provided.

Finally, K. S. Shaji and Amit Dias describe the situation in India, where, despite the best efforts of the Alzheimer's and Related Disorders Society of India (ARDSI), dementia remains a largely hidden problem. It is still widely seen as part of normal ageing. The majority of people with dementia are cared for at home, with little financial, practical or emotional support. There is a government network of services, but most people prefer to use the costly private system. Fortunately, there are several initiatives, arising from the 10/66 Dementia Research Group, by which local people are trained in dementia care. One scheme is being evaluated and has seen promising initial results.

These three articles reveal some common issues that need to be drawn to the attention of health and social policy makers in low- and middle-income countries. Endemic poverty among older people, the lack of government-funded health and social care systems and the shortage of trained personnel require urgent attention. New initiatives, especially the 10/66 Dementia Research Group, are already raising awareness among the public, health professionals and policy planners. The rapid ageing of the populations in these countries means, to quote the slogan for World Alzheimer's Day (21 September 2006), 'there is no time to lose'. Psychiatrists all over the world are urged to support their national Alzheimer's associations in all the activities they undertake to the very best of their abilities.

The rapid ageing of the populations in these countries means, to quote the slogan for World Alzheimer's Day (21 September 2006), 'there is no time to lose'.

Ageing and dementia in developing countries – the work of the 10/66 Dementia Research Group

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Demographic ageing proceeds apace in all world regions (United Nations, 2003). The proportion of older people increases as mortality falls and life expectancy increases. Population growth slows as fertility declines to replacement levels. Latin America, China and India are experiencing unprecedentedly rapid demographic ageing (Figs 1 and 2).

In the accompanying health transition, non-communicable diseases (including heart disease, stroke, cancer, arthritis and dementia) assume a progressively greater significance in low- and middle-income countries. This is partly because most of the world's older people live in these countries – 60% now and rising to 80% by 2050. However, changing patterns of risk exposure also contribute. In the third stage of health transition, as life expectancy improves and high-fat diets, cigarette smoking and sedentary lifestyles become more common, cardiovascular diseases and associated conditions, including dementia, gain maximum public health salience (Yusuf *et al*, 2001). Non-communicable diseases are already the leading cause of death in all world regions apart from sub-Saharan Africa (Fuster & Voute, 2005).

There are inequities in the increasing attention directed towards non-communicable diseases in low-

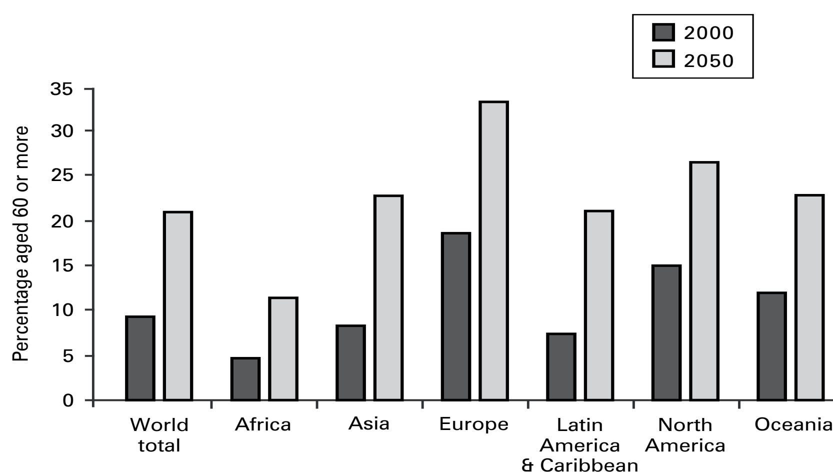

Fig. 1 Global demographic ageing: proportion of population aged over 60 in 2000 and predicted for 2050.

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