insurance in Russia. Modern therapy of chronic diseases such as hypertension and diabetes mellitus on a regular basis is barely available for many. Irregular treatment of hypertension has been a major problem in the former Soviet Union,[3] and an obvious contributor to cardiovascular and cerebrovascular mortality. Overestimation of cardio- and cerebrovascular mortality rates on one hand and of its cause-effect relationship with high alcohol consumption on the other[1,4] has obviously led to many deaths from undiagnosed and untreated diseases, poisoning, etc., to be ascribed to alcohol abuse, thus shifting responsibility onto the patients.

Finally, the methods used for quantitative estimation of alcohol consumption in some studies are worthy of note. The overall level of alcohol consumption in Russia has been estimated using the indirect method, on the basis of the incidence rate of alcohol-related psychoses.[4] This method may be adequate for countries with a stable quality of consumed alcohol, but not for Russia, where the quality of alcohol deteriorated after 1985 and especially during the 1990s,[1] having gradually improved since 2000 (personal observations). Psychosis-like conditions may be caused not only by ethanol but also by other substances present in low-quality alcoholic beverages and surrogates. Furthermore, misdiagnosis of neurological derangements after ingestion of toxic alcohol-containing fluids as psychosis cannot be excluded; overdiagnosis of psychosis was known to occur in the former Soviet Union.[5]

In conclusion, two significant causes of the relatively high mortality observed in Russia, especially among men, should be highlighted, although not clearly perceptible from the literature: the limited availability of modern healthcare and the toxicity of some alcoholic beverages. Offenses against alcohol abusers, aimed at appropriation of their residences and other property, are also known to occur in Russia, and should be mentioned as well.

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Disclosure

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Crack-cocaine addiction in an indigenous Brazilian: a case report

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A 20-year-old indigenous Brazilian moved to São Paulo for addiction treatment. He fulfilled DSM-5 diagnostic criteria for severe dependence for both crack-cocaine and marijuana. The patient first underwent inpatient treatment for detoxication, and was then referred to an outpatient facility. A multidisciplinary team managed his case. The patient identified as living in a sort of limbo; not part of indigenous culture, but not part of "the white man's culture." He had been moving his whole life, living some years in his home village and some years in the big city.

The indigenous population of Brazil has been growing. From 1991 to 2000, its growth rate was 10.8% per year.[1] According to the 2010 Brazilian census, there was 896,000 Indigenous Brazilians in the country, which represents 0.4% of the Brazilian population.[2] The coexistence of both indigenous and white culture, however, is not always harmonious. In recent years, their relationship has grown in intensity, though not always in harmony. Health care cannot be dissociated from a cultural comprehension-based approach. Although indigenous health has been investigated in Brazil, with particular focus on infectious diseases, metabolic syndrome and nutritional status, mental health is still a research gap.[3,4]

Although drug and alcohol dependence seem to be common among indigenous populations, a major gap in the literature remains. In a PubMed search, the only Brazilian study about this issue was an ethnographic investigation among the Kaingang people. It found that alcohol abuse was a stigmatized behavior, with the leader of each tribe being responsible for regulation of alcohol sales within the tribe. Furthermore, it is also the leader's role to restrain inappropriate behaviors related to alcohol intoxication. Persons in a state of intoxication are usually tied to a trunk, where they remain until sober. This punishment process is public, in order to increase the odds of behavior change. Lately, in this tribe, Protestant leaders have been getting closer to indigenous culture in order to develop treatment and prevention strategies for alcohol abuse. In this situation, indigenous Brazilians are usually asked to abandon some aspect of their traditional culture.[5]

To enhance the treatment of this patient, the team decided to focus more on his cultural background. Therefore, an educator joined the healthcare team. Her interventions consisted of daily meetings, in which the history of the patient's ethnicity and their language were taught to him. During the treatment, his grandfather, the tribe shaman, conducted a traditional healing ritual. After three months, abstinence was achieved. After he left

São Paulo, he continued treatment in his home village, at Xingu Indigenous Park.

In summary, investment on research about indigenous mental health specificities is mandatory. Research should focus on epidemiological surveys and clinical trials that include traditional treatment approaches, as their data could lead to better health care for a specific minority group. Health professionals that deal with indigenous populations should be trained to identify common mental health disorders. Mental health networks must be developed to provide psychopharmacology and psychosocial treatments. A proper treatment plan must take cultural differences into account and should try to establish links between Western and traditional medicine.

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Prevalence of self-injurious behavior in people with intellectual development disorder

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Self-injurious behavior (SIB) is a serious problem in people with intellectual development disorder (IDD). Such behaviors result in body lesions, elicit expression of negative emotions in caregivers, impair daily life interactions, and are associated with institutionalization and poorer quality of life. The frequency of SIB in people with IDD has not been studied in Brazil, and international studies suggest it is highly variable.[1-3] To assess the frequency of this behavior, patients from three institutions dedicated to the care of people with IDD were invited to participate in this study. Centro Nossa Senhora d'Assumpção (CENSA; n=107) is a specialized shelter for people with IDD. TheMadre Gertrudes (n=120) and Floresta (n=86) units of Fundação Dom Bosco are institutions focused on teaching and clinical care for this population.

For the purposes of this study, teachers, caregivers, and health professionals that had regular contact with the patients answered the Aberrant Behavior Checklist - Community (ABC-C).[4] The tool takes into consideration the individual's behavior in the preceding 4 weeks and consists of 58 items to be marked with scores on 0 to 3, where: 0 - it is not a problem in any way; 1 - the behavior is a problem, though light in severity; 2 - the problem is moderately serious; and 3 - the problem is severe. Patients that scored in any one of the items 2 (hurts himself on purpose), 50 (hurts himself deliberately), or 52 (uses physical violence towards himself) were considered positive for SIB.

Most participants with IDD were male (199 of 313; 63.58%). The mean (SD) age was 18.3 (12.4) years, ranging from 2 to 50 years. One-quarter of participants (n=76; 24.28%) exhibited SIB. Of those, 53 were male (69.74%) and 23 female (30.26%) (p=0.19). In CENSA, 25.23% of the patients exhibited SIB, whereas in the Madre Gertrudes and Floresta units of Fundação Dom Bosco, 20% and 29.06% of participants were self-aggressive. The frequency of SIB did not differ significantly between the institutions.

As this study shows, SIB is quite prevalent in people with IDD, both in specialized schools and at sheltering institutions. Our finding is in line with the study of Deb et al., who reported a 24% prevalence of SIB in IDD subjects living in the community.[3] These behaviors appear to be equally frequent in male and female patients. However, the tool used takes into account the opinion of an observer. Even though observers had regular contact with the patients, they might overestimate or underestimate the real frequency of SIB.

We do not have data in Brazil about the sensitivity or specificity of ABC for SIB. The present study has additional limitations, as we did not investigate the frequency of SIB throughout the patient's life, severity of IDD, or comorbid syndromes frequently associated with SIB,[5] such as the Lesch-Nyhan and Cornelia de Lange syndromes. Nonetheless, we hope these data may stimulate future studies that aim to provide a better understanding and perception of SIB in people with IDD.

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