

LETTERS TO THE EDITORS

Weighing the evidence for suicide prevention

Rev Bras Psiquiatr. 2015;37:264
doi:10.1590/1516-4446-2015-1684

We are pleased to note that, in early September 2014, the World Health Organization (WHO) published the first global report on suicide prevention, entitled *Preventing suicide: a global imperative*. Notably, this report states that the annual age-standardized suicide rate is 11 per 100,000 people, and that suicide is the second leading cause of death among people aged 15-29 years.¹

Of all suicides, 75% occur in developing countries.¹ This is especially important because WHO mentions that developing countries do not have an adequate system of registration for reporting of deaths by suicide, and that suicide accounts for 56% of violent deaths globally.¹

Suicide is a global public health problem for which preventive interventions are available, both at the individual level,^{2,3} e.g., by assessment and management of mental health problems, including tracking people with suicidal intent, and at the community level,^{4,5} by restricting access to means of suicide and reducing harmful alcohol consumption.² WHO notes that prevention plans in countries must be comprehensive and adopt an approach with predetermined parameters, but be flexible and adaptable to the culture and society which they address.¹

While various interventions to prevent suicide are mentioned in the report, the level of evidence for each of these interventions is not very clear. In developing countries, where the health sector lacks the resources needed to implement several of these suggested interventions, it is imperative to prioritize and choose the best and most cost-effective measures.

In conclusion, we consider the WHO report to be a very important tool both to know the position of suicide worldwide and to explain the variety of interventions that can be employed to help prevent it. While interventions are recommended, we believe it might be more helpful if each intervention had an evidence level that could help decision-makers prioritize.

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Submitted Feb 17 2015, accepted Feb 26 2015.

Disclosure

The authors report no conflicts of interest.

References

- 1 World Health Organization (WHO). Preventing suicide: a global imperative. Geneva: WHO; 2014.
- 2 Mann JJ, Apter A, Bertolote J, Beautrais A, Currier D, Haas A, et al. Suicide prevention strategies: a systematic review. *JAMA*. 2005;294:2064-74.
- 3 Matsubayashi T, Ueda M. The effect of national suicide prevention programs on suicide rates in 21 OECD nations. *Soc Sci Med*. 2011;73:1395-400.
- 4 Fountoulakis KN, Gonda X, Rihmer Z. Suicide prevention programs through community intervention. *J Affect Disord*. 2011;130:10-6.
- 5 Wasserman D, Hoven CW, Wasserman C, Wall M, Eisenberg R, Hadlaczky G, et al. School-based suicide prevention programmes: the SEYLE cluster-randomised, controlled trial. *Lancet*. 2015;385:1536-44.

Medical and societal aspects of alcohol consumption in Russia

Rev Bras Psiquiatr. 2015;37:264-265
doi:10.1590/1516-4446-2015-1682

The problem of alcohol misuse in Russia is immense, but there is a tendency to exaggerate it, as is evident to inside observers. This exaggeration tends to veil the shortcomings of the health care system, with responsibility for low life expectancy shifted onto the patients, i.e., it is attributed to self-inflicted diseases caused by excessive alcohol consumption.

During the anti-alcohol campaign of 1985-1988, widespread consumption of non-beverage alcohol products – including perfumery and technical fluids such as window cleaner – was observed, and in some instances caused severe poisoning. Considering the large scale of window cleaner sales in some areas, it was knowingly tolerated by authorities.

Alcohol consumption predictably increased after the end of the anti-alcohol campaign. Following the abolition of the state alcohol monopoly in 1992, the country was flooded with poor-quality alcohol, sold through legally operating shops and kiosks. About half of all cases of lethal intoxication with alcohol-containing fluids in some areas during the 1990s were caused by legally sold beverages, and a relatively low blood alcohol concentration was detected in many lethal cases.¹

As discussed elsewhere, veiled propaganda of alcohol consumption was perceivable through 1970-1985 and probably took place earlier as well.² Retrospectively, it is clear that the 1985-1988 anti-alcohol campaign was used for the same purpose: its failure and rebound effect were predictable and occurred when required. In this author's opinion, widespread alcohol abuse after the end of the anti-alcohol campaign facilitated the economical reforms of the early 1990s, including privatizations of state-owned enterprises.

With regard to health care, medication costs for out-patient treatment are not covered by compulsory medical

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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Submitted Feb 14 2015, accepted Mar 16 2015.

Disclosure

The authors report no conflicts of interest.

References

- 1 Nuzhnyi VP, Kharchenko VI, Akopian AS. [Alcohol abuse in Russia is an essential risk factor of cardiovascular diseases development and high population mortality (review)]. *Ter Arkh.* 1998;70:57-64.
- 2 Jargin SV. On the causes of alcoholism in the former Soviet Union. *Alcohol Alcohol.* 2010;45:104-5.
- 3 Roberts B, Stickley A, Balabanova D, Haerpfer C, McKee M. The persistence of irregular treatment of hypertension in the former Soviet Union. *J Epidemiol Community Health.* 2012;66:1079-82.
- 4 Razvodovsky YE. Alcohol-attributable fraction of ischemic heart disease mortality in Russia. *ISRN Cardiol.* 2013;2013:287869.
- 5 Jargin SV. Psychiatry in Russia: economic upturn must bring improvements. *Rev Bras Psiquiatr.* 2010;32:460-1.

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

Rev Bras Psiquiatr. 2015;37:265-266

doi:10.1590/1516-4446-2015-1726

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