LETTERS TO THE EDITORS

Weighing the evidence for suicide prevention
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We are pleased 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.5 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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Medical and societal aspects of alcohol consumption in Russia
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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 outpatient 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, 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 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. 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, 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.

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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