Authors’ reply: Inoue & Fujita made the point that clarifying the criteria of NSSI in DSM-5 facilitated discussion on the topic of suicide prevention. The problem of rising suicide rates among the younger population of Japan was also highlighted. Suicide has been identified as a leading cause of death in young Japanese people, with a significant societal impact. We would agree on the importance of fostering discussion and understanding of suicide at national and international levels. We would also agree that addressing suicide prevention among younger age groups is a public health priority for many countries.

Internationally, suicide rates in younger people have increased over the past 50 years. This phenomenon is apparent in Ireland where we now have the fourth highest youth suicide rate (under 25 years) in the expanded European Union. In May 2013 the Suicide in Ireland survey was published, a national research study exploring Irish suicide statistics, with a focus on young lives lost to suicide. This study identified a fourfold rate of increased suicide risk in males between the ages of 16 and 20, compared with after 20 (113.1 v. 28.2 cases per year). A similar twofold increasing trend was noted for females (12.7 v. 7.4 cases per year). Contributory factors to suicide risk in young adults in Ireland included bereavement, relocation, relationship break-up, bullying and assault. Inoue & Fujita propose that bullying is a factor that should be explored in tandem with studies of youth suicidality. This is supported by a growing evidence base internationally that bullying is a key antecedent for suicide, particularly when experienced at an early age.

Suicide rates and associated risks vary across countries and cultures. There is a need for regional suicide research to understand the complexities specific to suicide within nations as well as larger-scale, international, cross-centre research to continue to build a robust evidence base on this issue. Future suicide prevention programmes may need to be revised and tailored to address the needs of specific age groups. Targeted, high-priority suicide prevention strategies can work when based on robust national and international research; evidence for this can be seen in the UK where suicide rates have been in decline over the past 5 years, coinciding to a degree with the implementation of the National Suicide Prevention Strategy. However, suicide prevention remains a moving target – the recent national confidential inquiry into suicide in the UK does support a fall in suicide rates between 2001 and 2010 as well as a fall in male suicide rates under the age of 25, but it also showed a possible increase in suicide rates among mental health patients in 2011. This reiterates the point that the focus of prevention should potentially be group specific, depending on the needs of the population involved.

1 Yip PSF. Suicide in Asia: Causes and Prevention. Hong Kong University Press, 2008.
Computer-assisted therapy for medication-resistant auditory hallucinations. *BJP*, 202, 428–433. The heading of Table 3 (p. 431) should read: Comparison of the three main outcome measures between the delayed therapy and the immediate therapy groups after randomisation (baseline) and at the first follow-up, after some patients had dropped out of both groups.

Magic bullet thinking – why do we continue to perpetuate this fallacy (letter)? *BJP*, 203, 154. The name of the first author of this letter is Julia J. Rucklidge. The online version of this item has been corrected, in deviation from print, and in accordance with this correction.

Risperidone-induced hypersexuality (letter). *BJP*, 203, 233. Second paragraph, frequencies of intramuscular injection were reported incorrectly. The paragraph should read: Mrs X, 71 years old, married once and widowed for 20 years, with no known history of hypersexuality, was started on risperidone 25 mg intramuscular (IM) injection three weekly. Two months later, she complained of ‘having to’ masturbate two to three times daily without being able to orgasm, lactating and losing ‘too much fluids’ vaginally. She became fixated on an imagined romantic relationship, took off her old wedding ring and attempted to hire a tourist boat for a wedding reception she planned for herself. Risperidone was stopped after 6 months and switched to pipotiazine 25 mg IM injection, three weekly, after a washout period of 5 days. Features of hypersexuality waned and resolved 10 days later, with no recurrence.

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