randomly selected sample of suicide by hanging from a wide geographical area in England.

We would like to make the following comments. The report made no reference to the proportion of older victims in the randomly selected sample. The mean age given in the report (41 years) is almost the same as that for all people over the age of 16 years in England and Wales who hanged themselves in the same year as the study (2001) and over the past 23 years. These cases include, on average, 16% over the age of 64 years. This means that the study sample of 162 contained at least 25 victims over the age of 64, a sizeable older element that was not referred to in the report.

This is important and ought to have been clarified particularly in relation to the deaths that occurred in hospital when the victims were found seated (4.7%), kneeling (7.4%), lying (8.7%) or partially suspended (3.4%) and to individuals who were found alive (4.3%). However, this does not apply to hanging in prison where victims had an estimated mean age of 28 years (Shaw *et al*, 2004).

We calculate the expected annual rate of 'potentially preventable suicides by hanging' within institutions (controlled environment) in England and Wales to be about 110 cases of a total of 1300 expected annual suicides by hanging: 86 in prison (Shaw *et al*, 2004) and 24 (about a third of 71 hanging incidents by psychiatric in-patients) in hospital (Department of Health, 1999). 'Potentially preventable suicide by hanging' in controlled environments involving prisoners represents 5% of all suicide by hanging in England and Wales and 2% in the case of psychiatric in-patients. This is remarkably similar to the 6% in the report of Bennewith *et al*.

It would be of real interest, and certainly of practical value, if future studies specifically investigated suicide by hanging within controlled environments such as hospitals and prisons using an appropriately selected sample over a period of time (e.g. 220 incidents expected over 2 years in England and Wales, based on current figures). This would provide a study with acceptable power and some inferential value compared with the modest 10 cases reported by Bennewith *et al*.

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Authors' reply: The aim of our research was to undertake a detailed assessment of a sample of *all* (community and institutional) suicides by hanging in a defined geographical area over a 6-month period, focusing on potentially preventable aspects of these deaths. The context for the research was the rise in suicides by hanging in England and Wales (Gunnell *et al*, 2005) and the National Suicide Prevention Strategy for England (Department of Health, 2002). Of note, rates of suicide by hanging have not increased among men or women aged 65 years and over (Gunnell *et al*, 2005). Although generally Office for National Statistics figures for England and Wales from the 1970s onwards show that rates per 100 000 for deaths by hanging were higher in those aged 65 and over compared with rates in other age groups, this is not the case from 2000 onward when rates for death by hanging increased in the 15- to 44-year age group and decreased among those aged 65 and over (Gunnell *et al*, 2005).

The Editor decided that our paper should be resubmitted as a short report. The limited space did not enable us to give a full breakdown of the distribution of age, gender, race, social class, etc. of all of our sample. In response to the concern of Drs Salib and Theophanous we can confirm that 13 (8.0%) of the 162 cases in our study were aged over 65 years. Furthermore, 19 (11.7%) were aged under 25 years and 139 (85.8%) were male.

For those interested in a more detailed account of suicides in psychiatric hospitals and prisons we suggest the following sources: Dooley (1990), Shaw *et al* (2003), Shaw *et al* (2004) and Gunnell *et al* (2005).

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Transcranial direct current stimulation in developing countries

The suggestion by Fregni *et al* (2005) that transcranial direct current stimulation (tDCS) might be an inexpensive solution to the lack of resources for the treatment of depression in developing countries is well meaning but does not take into account the real reasons for the poor uptake of psychiatric treatments. If, as the authors state, the uptake is only 34% in a resource-rich country such as the USA with its high educational levels and awareness campaigns, a rate of 17% in Brazil is not surprising and is most likely not due to the lack of affordable drugs (Chisholm *et al*, 2004). Cheap and effective, if not the latest, antidepressant drugs are usually available in most countries. In making their suggestion, the authors also ignore the expert opinion regarding the first-line management of depression around the world (Crawford, 2004). Most commentators would agree that this should be pharmacotherapy and not direct magnetic or electrical stimulation of the brain. The lack of primary healthcare facilities in many countries makes the suggestion of tDCS as a primary intervention impractical.

My major concern, however, is not that the authors recommend tDCS as a first-line intervention but that they recommend it as an intervention at all. By basing their

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