

utilisation is not accompanied by a substantial decline in the suicide rate, it does not mean that better and more widespread treatment of depression is not helpful for preventing many suicides. While the overall suicide rate of Australia and Northern Ireland (two countries with traditionally low suicide rates) have not substantially decreased during the past 10 years, a significant association between increased antidepressant use and decreased suicide rates in different age cohorts has been reported (Hall *et al*, 2003; Kelly *et al*, 2003).

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Authors' reply: We have data on the suicide rates by gender from 1978 to 2000. The average rate for that period is about 19 per 100 000 for men and about 5 for women. The yearly data series for women is a sequence of numbers varying from 3 to 14. Because of the small number of female suicides they can vary considerably. Even 5-year averages would have large standard deviations. If an over-dispersion coefficient of 2 is assumed, the size of the standard deviation in 5-year averages should be around 1.4 for women and 2.6 for men. Therefore, observed 5-year averages of 4–7 for women and 17–22 for

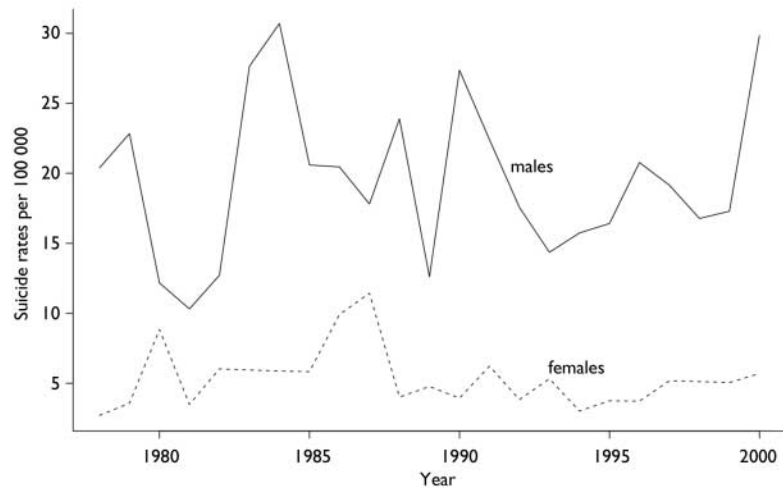


Fig. 1 Observed suicide rates in Iceland per 100 000 by gender.

men could be expected. Average rates may vary according to choice of 5-year periods (Fig. 1). The rates during 1995–1999 were 18.1 for men and 4.6 for women, but 21 for men and 5 for women during 1996–2000. The rates quoted in Isacsson's letter for 1995–1999 are actually for 1995–1996 (Levi *et al*, 2003) and too low. Taking 5-year averages is a waste of information because it ignores the time series structure in the data. With such limited data as the number of suicides in Iceland it is vital to use statistical techniques that use data as efficiently as possible. In this case the dynamics of suicide rates seemed to be similar for both genders, so data on them was pooled. In our opinion time series methods should be used for these data as they take advantage of the time series structure of the data. Furthermore, a time series approach leads to improved *P* values and decreases the possibility of spurious regression (Granger & Newbold, 1974).

In our paper (Helgason *et al*, 2004a) we mentioned that suicide rates had not decreased in Norway since 1995 in spite of increasing antidepressant sales.

In 1989 the amount of antidepressants prescribed was 13.9 defined daily doses per 1000 per day for men and 27.6 for women aged ≥ 15 years (Helgason *et al*, 1997). The amount prescribed in 2001 had increased to 66.8 and 119.1 defined daily doses per 1000 per day for men and women, respectively (Helgason *et al*, 2004b), i.e. a slightly greater increase for men without affecting suicide rates for either gender.

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Transcranial direct current stimulation

Kurupparachchi & Wijeratne (2004) support the use of innovative and cheaper treatments for depression in developing countries. In Brazil, for instance, antidepressants are scarcely available in the public sector and the delivery of these drugs is irregular, hence hindering long-term treatment. A recent study showed that only 17% of primary care patients with current depressive disorder in Brazil received any treatment for their depression. In comparison, 49% and 34% of patients with similar conditions in Australia and the USA, respectively, received treatment for