



the columns

correspondence

Trends in mental health googling

For good or ill, google.com plays a growing role in all aspects of life, including mental health. This is true for professionals, who may google medical literature, diagnoses,¹ patients² and, one supposes (as this is not yet supported in the literature), google each other. Patients, their families and other interested parties are googling too.

It is now possible, via Google trends (www.google.com/trends) and its sister Insights for Search (www.google.com/insights/search/) to obtain information about the relative frequency of Google searches for various terms. Comparisons can be made between search terms over time (since 2004) and between geographical areas. Clearly, mental health-related searches are not uncommon. Worldwide, in the period from July 2008 to July 2009, 'depression' was searched for nearly as often (approximately 84% as frequently) as 'Barack Obama'.

'Depression' as a term is googled five times more often than 'schizophrenia'. This is presumably for a myriad of reasons – its use as an economic and meteorological term among others – but it possibly reflects its greater prevalence.

'Suicide' searches occur at about the 80% of the frequency of depression searches. Small numbers of searches are made for topics such as 'suicide how to' and 'suicide methods' (approximately 30 times less frequent than searches for the term suicide).

'Bulimia' is a search term of modestly declining interest over the past 5 years, whereas the concern expressed by various quarters about the 'pro ana' movement seems justified because in the UK and Ireland, for every three searches for 'anorexia' there is one search for 'pro ana'. Perhaps French women 'do not get fat'³ because France is the country in which 'pro ana' searches are the most popular.

Finally, one can deduce from Google that advertising does work, as people google trade names far more commonly than generic names for drugs: since 2004, 'Prozac' was googled four times more frequently than 'fluoxetine'.

1 Tang H, Ng JHK. Googling for a diagnosis – use of Google as a diagnostic aid: internet based study. *BMJ* 2006; **333**: 1143–5.

2 Neimark G, Hurford MO, DiGiacomo J. The internet as collateral informant (letter). *Am J Psychiatry* 2006; **163**: 1842.

3 Guiliano M. *French Women Don't Get Fat*. Knopf Publishing Group, 2004.

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Qualitative outcome for community treatment orders

The new Mental Health Act 2007 introduced supervised community treatment orders (CTO) as an additional tool for management of complex service users who have a disorder of the mind. The theoretical framework for CTO use and implementation has been clearly highlighted in the current literature. However, there is limited knowledge about outcomes. Questions arise about reduction in admission rates, actual CTO numbers, duration, recall and revocation. Consultant opinions are greatly valued in the practical administration of the tool.

We conducted an audit looking at the first 6 months of CTO implementation in the Cheshire and Wirral Partnership National Health Service Foundation Trust. The trust covers a population of 1 million distributed over four hospitals.

A total 67 CTOs were implemented. Further analysis showed that 66% of those who received them were male; 33% had two consultants because of the acute care model (one in-patient and one community consultant). Analysis by diagnosis demonstrated variety: schizophrenia 66%, schizoaffective disorder 22%, bipolar affective disorder 6%, persistent delusional disorder 3%, and non-organic psychosis, eating disorder and personality disorder 1% each. There was a gradual reduction in CTOs over the 6 months, with a peak in December ($n = 19$) to a low in April ($n = 4$).

When we consider necessity, 100% of CTOs were implemented with regard to patient's health, 87% for safety and 70%

for protection of others. The grounds on which opinion whether to apply the CTO was founded and recorded most frequently were: diagnosis 75%, risk 63%, nature of the mental disorder 57%, and non-adherence 55%. Surprisingly, multiple admissions and repeated detentions were low at 3 and 7% respectively.

A wide variety of discretionary conditions were used, which raises the question of social control with flexibility and creativity of use. These were: access to community mental health team or assertive outreach team 67%, residence at designated address 61%, out-patients' department 52%, medication adherence 51%, depot medication 19%, adherence to treatment plan 12%, physical examination 6%, abstaining from alcohol 3%, access to crisis resolution and home treatment team 1%, return to hospital 1%, and accept support 1%.

There was a total of nine recalls which were converted to nine revocations. The earliest recall was after 2 days and the latest after 3 months. Post-revocation, there was one new CTO, one discharge and seven detentions under Section 3 of the Mental Health Act.

Before receiving a CTO, 60% of the sample were detained under Section 3 and 40% under Section 25. After receiving the CTO there were four informal admissions. Time frame to CTO completion varied from 40% on the same day to 72% within 1 week; the longest took 79 days. In 18% of cases, second-opinion assessment was overdue. A wide variety of psychotropic medications and mood stabilisers were used.

All the consultants who had used the CTOs were emailed and a sample of responses included the following general themes: CTOs provided a contractual agreement to care facilitating quicker discharge, yet the threshold for recall was not clear; CTOs avoided the practical inconvenience and intimidation that can be generated when conducting a Mental Health Act assessment; an acute care model the framework for the most appropriate named responsible clinician is yet to be formalised; the practical administration processes involved raised concerns about the time commitments involved.