Perhaps French women ‘do not get fat’3
Ireland, for every three searches for
whereas the concern expressed by various
declining interest over the past 5 years,
times less frequent than searches for the
and ‘suicide methods’ (approximately 30
searches. Small numbers of searches are
80% of the frequency of depression
is presumably for a myriad of reasons ^
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 than ‘fluoxetine’. ‘Prozac’ was googled four times more
than generic names for drugs: since 2004,
that advertising does work, as people
googling

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 profes-
sionals, who may google medical litera-
ture, diagnoses, ‘patients’ and, one
supposes (as this is not yet supported in the
literature), google each other. Patients, their families and other inter-
ested 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
deciding 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’1,3
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
googling
googling

1 Tang H, Ng JHK. Googling for a diagnosis – use of
Google as a diagnostic aid: internet based study.
2 Neimark G, Hurford WD, DiGiacomo J. The Internet
as collateral informant (letter). Am J Psychiatry
2006; 163: 1842.
3 Guillaume M. French Women Don’t Get Fat. Knopf

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Qualitative outcome for
community treatment orders

The new Mental Health Act 2007 intro-
duced supervised community treatment
dorders (CTO) as an additional tool for
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implementation has been clearly high-
lighted 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 diag-
nosis demonstrated variety: schizophrenia
66%, schizoaffective disorder 22%,
bi-polar 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 deten-
tions 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 examina-
tion 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
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.

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