



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'.

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- 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.

A CTO is a flexible tool in the early stages of actual use in the community. Gathering the quality outcomes is still at an infancy stage and a balance is required to protect service user rights while keeping administration protocols to its minimum.

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Internet and doctors' security – how exposed are you?

We have read with some concern on the College website the highlighting of personal information on electoral registers, its availability to the general public and the consequent security implications for mental health professionals. Members of the public have access to the edited electoral roll containing information such as home address, but as advised on the website, we can choose to opt out of this particular register.

Other than the electoral roll, doctors should also exercise caution as to how much personal information they divulge when using the internet and be aware as to how this information is shared and how accessible it is to others. The use of social networking sites has increased in recent times and search engines have become more advanced in seeking out information. When using them, extra security precautions should be taken.

Clearly, the more information we reveal and others divulge about us, the more information someone can use to build a comprehensive profile about us. This led us to conduct a qualitative study involving 18 mental health professionals from different disciplines of the same team. Each member was asked to conduct a basic internet-based search engine query about another team member. From the search results we listed what information could be sought about that person. None of the information we collected involved monetary payment.

The results showed personal information about team members and consequent security risks. For a profession that is focused on risk assessment, we are not as cautious in our private lives. We were able to ascertain information about family details including children, personal photographs, personal telephone numbers and home addresses, dates of birth, workplace information and in one case, particular information where and when that person was going to be on a particular day. We were even able to discover which books a member of the

team had bought online and which ones they wished to purchase.

We believe this is all potentially sensitive information which could be used with disastrous consequences such as identity fraud, harassment, stalking or worse, acts of violence. We are not just making targets of ourselves but also of friends and family. As workers in a discipline where risk is continuously considered, we should exercise caution as to the information we share in our private lives.

We do not wish to act as killjoys, advising not to use social networking sites, but we advocate using extra steps to limit information availability and to seek advice on how to limit breaches of security. This advice applies not only to psychiatrists but to all healthcare professionals.

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The 'special' ones: survey of Laughlin Prize winners

It is with a mixture of admiration and slight envy that I look upon those who triumph as best of the best in tough competitive examinations. Surely, to emerge on top they have to be 'special'. The Laughlin Prize, established in 1979, is awarded after the spring and autumn MRCPsych Part II examinations to the candidate obtaining high marks and the best recommendation from the examiners.

Given the above, I wished to find out more about the winners, their preparation for examination and whether winning the prize influenced their later career choice. I also hoped that the information obtained from this exercise would inspire trainees preparing for MRCPsych examinations. So I set out to conduct a postal questionnaire survey of all winners and contacted the College for a list of names. However, for confidentiality and data protection reasons, I was only given the names of those who won the prize since 2000.

I piloted the questionnaire on one winner; the final version was designed to gather some demographic information and also consisted of open-ended questions such as 'Did winning the prize influence your career in any way?', 'Did winning the prize change others' perceptions of you?' and 'Was your preparation for the examination any different?' I sent out the questionnaire to the 12 winners identified and received

seven replies. Below is a brief summary of the results.

Mean age 33 years (range 27–40); gender: male 5, female 2; ethnicity: White 5, Indian 2; country of medical training: UK 4, India 2, Australia 1; current subspecialty: general adult psychiatry 3, child psychiatry 1, old age psychiatry 1, liaison psychiatry 1, forensic psychiatry 1; self-rating of the importance of the prize in terms of career path (rated on a scale of 1–10): 5.7 mean, range 2–8.

Five individuals reported that winning the prize did not influence their career in any significant way, although four of them felt that maybe it did help them get jobs and increased their overall confidence. Two respondents felt that it did influence their career choice (one towards a clinical career and one towards an academic post). Only one person said they probably worked harder than their peers, whereas others said their exam preparation was no different. Interestingly, two respondents said: 'I tried to enjoy the clinical examination', and 'Before the exam I realised that I had become too goal-orientated and that I needed to start enjoying being with patients'.

In summary, given the limited number of responses, no valid conclusions can be drawn. The predictive validity of the Laughlin Prize could also not be assessed, as the sample only comprised winners since 2000. Although there were more males (5/7) and White individuals (5/7) in this cohort, given the sample size, attempting to explore reasons for that would be merely speculative. Majority rated the prize highly in terms of its importance in their career path, although only two respondents actually felt it influenced their subsequent subspecialty or academic/clinical career choice. It is to be noted that those who said the prize did not influence their career choice had already made clear plans for their future, even before taking the examination. Although most respondents (6/7) said their preparation for the examination was no different to their peers, it is worth noting that two reported trying to 'enjoy the experience'. This might be an important message for trainees in that rather than trying to see the exam as an 'artificial' and stressful experience, maybe they should anticipate it as more of an enjoyable experience, no different to their daily doctor–patient interactions.

Having read through the responses (and as was pointed out by one of the winners), it was felt that the winners of the Laughlin Prize were inadequately acknowledged for their achievement. Surely to be the best among a cohort of 500-odd doctors is no mean feat and is indeed, in my view, something special. If future trainees are to be inspired to work harder, maybe the College (Exams Department) could do more to