

which is more consistent with rates in the literature, although it still remains on the lower end. Moreover, we re-analyzed the logistic regression analysis for the 12-month data and found that all variables that had been significantly associated with lifetime psychotic experiences in our original analysis remained significant (that is, being Latino, being black, lifetime prevalence of posttraumatic stress disorder, and higher lifetime distress). An additional variable—living in the South versus the West—was found to be significantly associated with reduced rates of psychotic experiences. We have posted a copy of the reanalysis as a data supplement to the original article.

Finally, at the request of the peer reviewers of the manuscript, we included the 12-month prevalence data in our revision, although we believed that this item had a number of deficiencies. We expressed our concern about this variable in the paper, and now Mr. DeVlyder has identified some other differences between the 12-month and lifetime items. Thus the reader should use appropriate caution in interpreting the 12-month findings.

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GP's and New Compulsory Admission Procedures in France

To the Editor: On August 1, 2011, a new law reforming compulsory hospitalization measures (CHMs) was implemented in France (1). This new law aimed to develop compulsory community treatment procedures and to introduce review by a judge (2). Although a reform of CHMs was long expected in the French psychiatry field, numerous professionals expressed disapproval of the speed with which the new law was drafted and implemented (2). Such precipitance could notably disrupt physicians' ability to correctly carry out CHMs.

In a single-center retrospective study, we collected all compulsory admission certificates (CACs) written by private-practice general practitioners (GPs)

for outpatients referred to the psychiatric unit of our emergency department from August 1, 2010, to July 31, 2012—that is, one year before and one year after official implementation of the new law. We divided the CACs into two periods: those written before August 1, 2011 (before implementation of the new law) and those written after this date and officially underlined by the 2011 law. For both periods, we assessed whether each CAC was formally valid according to the previous law criteria, formally valid according to the new law criteria, or formally invalid according to both laws. We compared the proportions of invalid CACs in the two periods by using chi square tests. The study was approved by a national ethics committee.

A total of 119 CACs fulfilled the selection criteria: 57 CACs were written in period 1, and 62 were written in period 2. During period 1, 30% of CACs (N=17) were found formally invalid, compared with 52% (N=32) in period 2 ($p<.05$). Of the CACs in period 2, 21% met prerequisites of the previous law.

Our findings show that, locally, GPs' skills in performing CHMs appeared significantly affected by implementation of the new law. In period 2, more than 20% of GPs continued to write CACs according to the requirements of the previous law. It appears that they ignored the existence of the new regulation, which supports the view that numerous professionals were insufficiently prepared for the change. However, the rate of invalid CACs was already high even before the change, because almost 30% of CACs were formally invalid in period 1.

Our study was conducted at only one center, and it is unclear whether this finding is local or reflects a more widespread issue. Nevertheless, the finding could point to a lack of training on CHMs among GPs. Many GPs are recurrently confronted by situations requiring CHMs, but these situations may not be routine enough to produce expert skills in writing CACs. Moreover, CHMs may be insufficiently addressed within continuing medical education programs.

Committing patients under invalid CHMs is equivalent to an unjustified deprivation of freedom, which might expose physicians to medico-legal consequences and which raises important ethical concerns. In several European countries, only trained psychiatrists can carry out CHMs (3). In the other countries, including France, any physician can do so. However, physicians' skills in regard to CHMs should be more carefully examined.

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Google Searches for Suicide and Risk of Suicide

To the Editor: Routine surveillance of disease incidence is a core function of public health programs (1). Surveillance systems for mental disorders, however, remain underdeveloped

despite strong temporal variation in the incidence of these disorders. Recently Google, the most commonly used search engine in the world, launched "Google Trends." This Web site allows the public to gather statistics on queries made to the Google.com search engine. To the extent that depression—a key risk factor for suicide—and suicidal ideation presage an increased risk of suicide completion, surveillance of Google Trends queries may assist with focused bursts of suicide prevention efforts. We tested whether suicide-related Google searches predict the monthly incidence of completed suicides. We examined England and Wales because of their publicly available suicide database and their high societal cost of premature death from suicide (\$9.2 billion in 2009) (2).

We obtained data on suicide incidence for January 2004 to December 2010, the longest series that overlaps with Internet-based suicide queries. We defined suicide by using conventional *ICD-10* classification schemes. We used as independent variables the monthly Internet-based queries by individuals in England and Wales for a series of search terms that have been shown to be related to suicide ideation (3,4). We examined three distinct sets of terms: suicide methodology (suicide; suicide and methods), depressive symptoms (suicide and depression; depression; depression and help), and suicide help (suicide; help). To statistically control for temporal patterns in suicide (for example, seasonality), we applied rigorous time-series routines

(5). [More details about the time-series routines are included in an online data supplement to this letter.] We further controlled for the unemployment rate and Google searches in the news, which often peak after suspected suicides of popular personalities (for example, singer Amy Winehouse) but may not signal increased help seeking or depression.

For the three searches that included the term "depression," we found a positive relation with search volume and suicide in that month. The strongest positive relation occurred between the Google Trends query for "depression and help" and suicide incidence in the same month (coefficients at lag 0 months = .004, standard error [SE] = .001, $p = .002$). We estimate that Google searches statistically accounted for a 7% increase in suicides during months in which search volume for "depression" increased. However, none of the Internet searches predicted the incidence of suicide in the following month. Moreover, we found no relation between searches for "suicide" or "suicide and methods" and suicide incidence. [Results are further detailed in the online data supplement.]

We caution against inferring an individual's Internet search behavior, depressive symptoms, and suicide risk from our population-level tests. Temporal fluctuations in Google searches are indicators of a population-level interest, which cannot shed light on individual differences in suicide risk. In addition, our findings of a positive relation between Internet search volume for "suicide and depression" and

completed suicide in the same month cannot definitively establish that suicide-related searches precede suicide completion. Nevertheless, our findings indicate that current surveillance efforts for suicide may benefit from real-time use of Google-based Internet searches for depression.

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