Mike Fitzpatrick

Outdoor psychiatry

In recent years it has become fashionable to decry the policy, initiated in the 1960s and accelerating in the 1980s, of transferring people with long-term mental illness from institutions into various forms of care in the community. Now widely scorned as a policy driven by a convergence between radical anti-psychiatry and reactionary cost-cutting, community care has been blamed for pushing disturbed individuals onto the streets, where, in a number of highly publicised cases, they have killed themselves or other people.

'Care in the community has failed' the then health minister Frank Dobson told parliament in 1998, in an opportunist invocation of a popular prejudice. I recall thinking that this was a mean-spirited jibe at all those who, over the preceding decades, had striven to release the mentally ill from institutional confinement. Anybody who ever visited the back wards of the old asylums knows that, whatever the inadequacies of care in the community, it marked a historic advance in the treatment of people with serious mental illness. The glib global condemnation of community care fails to recognise the dramatic improvements in mental health services in recent years, and the range of imaginative initiatives that now exists.

As a GP in Hackney over the past two decades, I have witnessed a transformation in local mental health services. It is therefore a particular pleasure to find that two of Hackney's leading psychiatrists — Mark Salter and Trevor Turner — have produced *A Practical Guide to Outdoor Psychiatry*, which is informed by the experience of providing community mental health care in one of the country's most diverse and challenging neighbourhoods.[1] 'Keeping patients well' they write, 'requires a mix of money and therapeutic skills, a knowledge of social, welfare, cultural and housing arrangements, an awareness of basic medical and medication aspects, and a hard core of commonsense.' Their book covers all these areas and more, with wit and passion, with a sense of history and a shrewd awareness of the role of politics and the media.

The prejudice that community care is a failure has been nurtured by one public 'serious incident' inquiry after another. As the authors acerbically put it, 'assaults with swords always get the headlines'. The result is the culture of 'risk management' and 'risk assessment', which the authors regard as 'the single most pernicious change in the delivery of mental health care in the last 20 years'. They blame 'the lawyers and the hindsight junkies creaming a living from the random misfortunes that happen to mentally ill people in a complex individualistic and unrealistic society.'

The authors warn that when risk becomes the basic criterion of services, mental health workers 'essentially become psychological dustcart drivers'. Major resources will be spent on a small number of people deemed (not necessarily accurately) to be a threat, while the vast majority of people who need help, but are not a danger, get overlooked. Furthermore, the risk agenda encourages a resort to coercive legislation (notably in the proposal to introduce preventive detention for those with 'dangerously severe personality disorder') and the return to diverse forms of institutionalisation.

Salter and Turner acknowledge that their handbook is written for somebody who does not yet exist — a professional community mental health worker. Still, it makes a valuable contribution by defining the skills, values, and training required by such a worker. I hope the book encourages the emergence of a generic mental health worker, who could give greater coherence to the work of struggling locality mental health teams.

Meanwhile, as GPs will continue to carry out a share of the tasks of community mental health care, *Outdoor Psychiatry* will be a useful guide, and the optimistic spirit expressed in its final sentence is an inspiration: 'Our business is unique and wonderful and the journey never ends.'

REFERENCE

1. Salter M, Turner T. *Community mental health care: a practical guide to outdoor psychiatry*. London: Churchill Livingstone, 2007.

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Top Tips in 2 minutes

Shoulders are important; Sir Isaac Newton noted that:

'If I have seen further, it is by standing on the shoulders of giants'.

For one of us, interest in the subject started at 11 p.m. on 8 April 2006 and can be mostly attributed to Wilson the black Labrador. The recipe for disaster was: killer heels (I had been out for dinner); one supine Wilson enjoying the delights of the Aga; accidental contact between heels and Wilson; a large dose of Newton's laws; a misguided attempt to interfere with Newton on my part. I've gone off Newton and the shoulder still hurts (Wilson, however, thrives).

Shoulder problems are responsible for significant levels of morbidity and disability, the prevalence in the general population is about 7% (though rising to 26% in the elderly). Most people with shoulder pain don't consult their GP, when they do the GP diagnostic vocabulary is a bit limited and vague. Outcomes are not impressive, with half still bothered by their symptoms after 1–2 years,[1] added to which the best evidence we have about effectiveness of interventions is related to what doesn't work.

This month's deceptively simple Top Tips in 2 minutes on shoulder pain should help you see further; having read it, you will be able to distinguish between rotator cuff syndrome and adhesive capsulitis, which are the commonest cause of shoulder pain.

However, the important research question must surely be: do shoulder pads, like hip pads, prevent injury? Answers on a postcard please.

Ruth Bastable, Sarah Rann and Vinny Barker

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REFERENCE

1. Linsell L, Dawson J, Zondervan K, *et al.* Prevalence and incidence of adults consulting for shoulder conditions in UK primary care; patterns of diagnosis and referral. *Rheumatology* 2005; **45(2)**: 215–221.

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Top Tips in 2 minutes: Sorting out shoulder pain.

Why:	Correct diagnosis will enable you to initiate appropriate treatment and to advise the patient on the likely prognosis. Although there are many causes of shoulder pain, identifying key clinical features will help distinguish between patients with two of the commonest causes of shoulder pain; rotator cuff tendinopathy and adhesive capsulitis (frozen shoulder).
How:	***History*** *Where do you feel the pain?* • Pain from the shoulder is usually felt in the muscles of the upper arm. *What makes it worse?* • Pain worse on shoulder movement, especially reaching out, up or behind, points to the shoulder as the origin of the pain.
	Examination *Compare active and passive range of movement* • Active abduction and active internal rotation are commonly reduced and painful in both adhesive capsulitis and rotator cuff tendinopathy. • Passive movements are reduced in adhesive capsulitis but usually near normal in rotator cuff tendinopathy. • In adhesive capsulitis active and passive range are nearly equal. • The finding of reduced external rotation is very helpful in identifying adhesive capsulitis. External rotation is well preserved in all shoulder problems except adhesive capsulitis and gleno-humeral arthritis (which is much less common). • Test external rotation by rotating the patient's hand outwards with the elbow flexed at 90º and kept tucked in close to the waist. • In adhesive capsulitis external rotation is significantly reduced compared to the normal side.
What next and when:	*Having identified adhesive capsulitis you should:* • Carry out a proper history and examination, with testing for diabetes and possibly a chest X-ray. Although most cases of adhesive capsulitis are idiopathic, there may be underlying pathology such as diabetes, or carcinoma of the lung. • Explain to the patient the typical natural history of the condition, which usually lasts about 18 months, but in the end resolves completely: 3–6/12 'freezing' — painful and very stiff 6/12 'frozen' — immobile but much less painful 6/12 'thawing' — gradual recovery of range • Interventions are not very helpful in the early stages. Steroid injections may give short term relief but do not alter the overall course. In the early stages physiotherapy is geared towards pain relief and very gentle exercises to maintain a little mobility. Overdoing the exercises will result in pain but will not help the movement. Physiotherapy exercises are more important in the third stage when muscle strength and joint mobility can be restored. • Prescribe adequate analgesia. In the early stages adhesive capsulitis pain can be severe and may require opiate analgesics and night sedation. • About 20% of patients will later develop adhesive capsulitis in the other shoulder.
	Having identified rotator cuff tendinopathy • Analgesics and/or short-term anti-inflammatories may help • Subacromial steroid injections may help • Physiotherapy — strengthening the rotator cuff reduces pain and improves function • Surgical referral may be appropriate in refractory cases, especially if there is subacromial impingement
Patient information:	Excellent leaflets on this and other conditions from Arthritis Research Campaign http://www.arc.org.uk/arthinfo/patpubs/6039/6039.asp
Web links/references:	There is a shortage of good studies on the effectiveness of interventions in shoulder pain. Useful reviews are to be found at: *BMJ Clinical Evidence* http://clinicalevidence.bmj.com/ceweb/conditions/msd/msd.jsp Shoulder pain interventions from the Cochrane Library http://www.jr2.ox.ac.uk/bandolier/booth/Arthritis/shoulder.html
Who are you:	Dr B Silverman, Associate Specialist in Rheumatology, Addenbrooke's Hospital Cambridge Dr J R Jenner, Consultant Rheumatologist, Addenbrooke's Hospital
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