the columns

correspondence

The first memory clinic in the UK

One of us was recently congratulated by their local primary care trust commissioner on having set up the first memory clinic in the UK. This was incorrect but that was the possible impression given in the first sentence of Dr Foy's interesting survey (*Psychiatr Bull* 2008; **32**: 467–9). The paper that she cites[1] described the Maudsley Memory Clinic that we think was the second in the UK but the first based within a psychiatric service. We ought to have cited the excellent paper by van der Cammen *et al*[2] that actually describes the first clinic at St Pancras Hospital but which had not been published at the time. Now that there is to be 'a memory clinic in every town' we thought we had better set the record straight.

1 Philpot M, Levy R. A memory clinic for the early diagnosis of dementia. *Int J Geriatr Psychiatry* 1987; **2**: 195–200.

2 Van der Cammen TJ, Simpson JM, Fraser RM, Preker AS, Exton-Smith AN. The Memory Clinic. A new approach to the detection of dementia. *Br J Psychiatry* 1987; **150**: 359–64.

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Out-patients: a necessary evil?

Recently, Magnes (*Psychiatr Bull* 2008; **32**: 458–60) conducted a survey of patient attendance posing the question 'Are out-patient appointments a necessary evil?' The need for out-patient appointments was both queried[1] and robustly defended.[2] Frequently, when discussing the role of such appointments the focus is on attendance.[3,4] However, research addressing other aspects would greatly benefit psychiatry.

We believe that the following issues could be considered: what is the purpose of out-patient appointments? (possible responses: (a) review mental state, adherence, risk, etc.; (b) opportunity for the patients to ask questions; (c) update the GP and/or other services involved; (d) consider referral to other members of the multidisciplinary team or other services); how often should we see patients and for how long? Furthermore, guidance on appropriate discharge procedures would be very helpful.

Finally, we would like to echo Holloway's[2] suggestion that 'a more nuanced discussion' on that 'necessary evil' is urgently required.

1 Killaspy H. Why do psychiatrists have difficulty disengaging with the out-patient clinic? Invited commentary on . . . Why don't patients attend their appointments? *Advan Psychiatr Treat* 2007; **13**: 435–7.

2 Holloway F. Engaging with the out-patient clinic: don't throw the baby out with the bath water. *Advan Psychiatr Treat* 2008; **14**: 159–60.

3 Mitchell AJ, Selmes T. Why don't patients attend their appointments? Maintaining engagement with psychiatric services. *Advan Psychiatr Treat* 2007; **13**: 423–34.

4 Kelly BD. Internal audit of attendances at a psychiatry outpatient clinic. *Irish J Psychol Med* 2008; **25**: 136–40.

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Ambivalence in eating disorders

Ambivalence towards recovery is a common feature among individuals with eating disorders,[1,2] particularly those with anorexia.[3,4]

The often valued and perversely positive role that an eating disorder (notably, anorexia) plays within a person's life[2] results in a fluctuating level of motivation to engage in therapy. This powerful degree of ambivalence plays a significant role in the high drop-out rates along the care pathway,[4] along with other factors identified in Waller *et al*'s recent study.[5]

It is surprising, therefore, that as yet there has been little research evaluating the impact of the different stages within the motivation cycle for change on treatment outcomes in individuals diagnosed with eating disorders.[2]

A standardised assessment of a person's level of ambivalence and drive for recovery, such as the Readiness and Motivation Interview[1] or similar, would not only provide guidance to the therapist as to an individual's likely initial level of engagement, but also facilitate a picture of their fluctuating level of motivation as they pass along the care pathway, allowing the therapist to tailor motivational techniques towards this. It would also enhance the quality of further outcome data relating to patient engagement with eating disorder services.

In Waller *et al*'s study, 13% of individuals offered out-patient therapy following initial assessment failed to engage with treatment. The waiting period between acceptance into the service and commencement of out-patient treatment is a critical stage in the care pathway, as a loss of 'momentum' through the service at this stage carries a significant risk of disengagement. In an attempt to counter this effect, the Birmingham Eating Disorder Service has recently introduced an 'awareness group', designed specifically for newly assessed and diagnosed individuals. The aim of the course of five weekly evening sessions is to consolidate initial engagement and bridge the gap between assessment and treatment, by providing information on eating disorders, treatment options and the structure of the service.

Although in its early stages, initial outcome for the group has proved positive, with 97% of those who attended for the initial session subsequently remaining engaged throughout the full 5-week course. On completion of the course, participants provided feedback on each topic covered on a ten-point Likert scale questionnaire (1, not at all useful; 10, very useful). Most of the ratings (89%) were 7 or above, with the physical consequences of eating disorders, comorbid psychological disorders and the effects of laxatives/vomiting

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