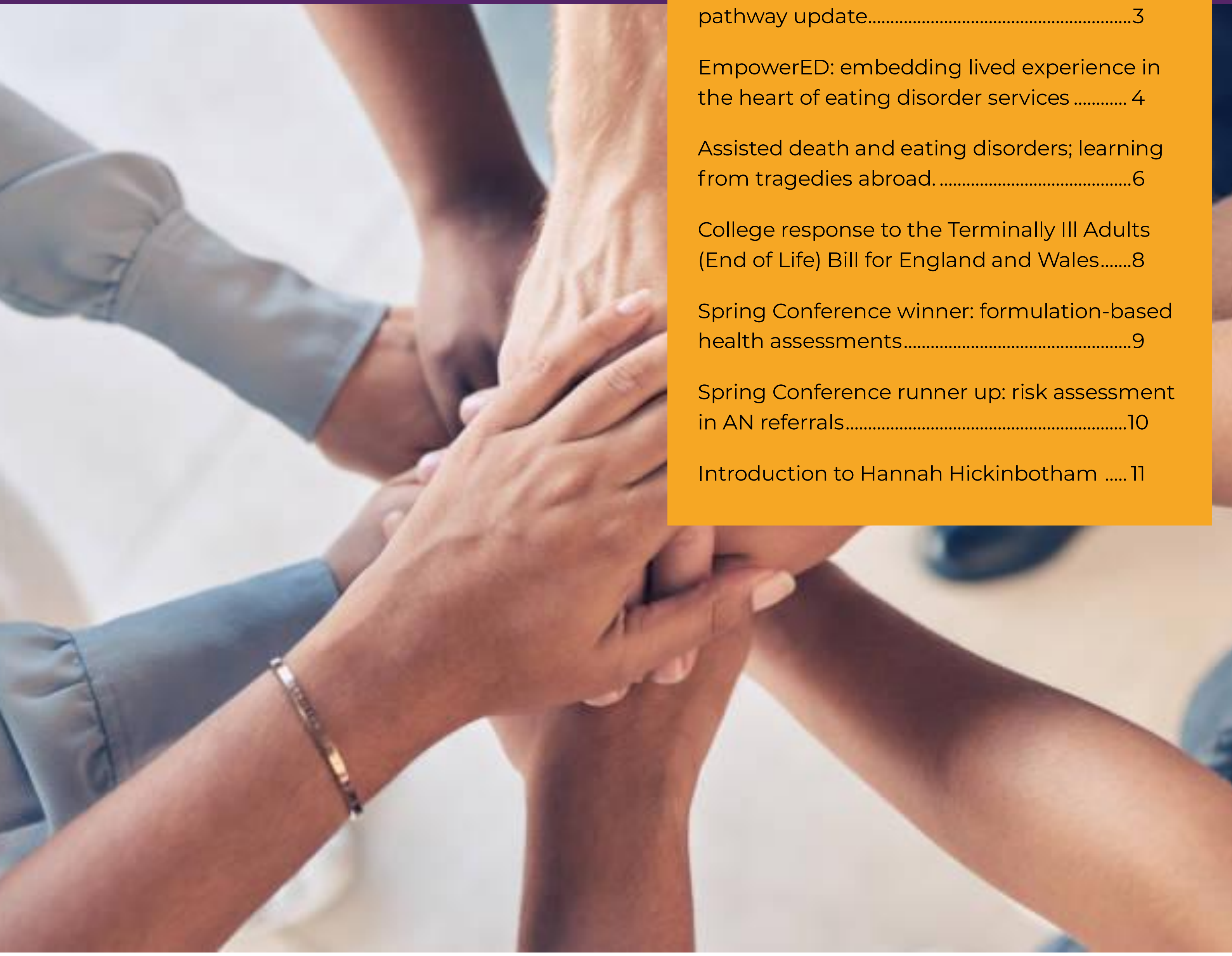
Newsletter

Summer 2025

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Eating Disorder Faculty

Contents



Vice Chair's report

Dr Agnes Ayton, Vice Chair, Faculty of Eating Disorders

Dear colleagues,

As we move into the second half of 2025, I wanted to share updates on our key areas of work across policy, clinical leadership, education and advocacy. Thank you for your continued support, collaboration, and energy in shaping the Faculty's work during such a pivotal period.

Policy and advocacy highlights

Closing the Gap: Addressing the Unmet Need in ED Prevention and Treatment

Thank you again to everyone who contributed to this major piece of work. We are working through the consultation and sign off phase with the College. This paper has already begun to influence wider work across the College, including our submission to the NHS long-term plan and input to the recent All Party Parliamentary Group (APPG) report on eating disorders.

The Chair and I continue to engage with the APPG —please do contact us if you are aware of any urgent priorities or local issues that should be brought to their attention.

Lived experience and complex presentations

Severe and Enduring/Long-Standing ED (LSED)

This continues to be the Faculty's top clinical and ethical priority. Professor Treasure and Ashish Kumar are leading on this project. Work is progressing on a new position statement that aims to promote evidence-informed, compassionate care while tackling some of the most complex challenges in our field. We are extremely grateful to the clinicians and individuals with lived experience who are contributing to this vital project, by participating in focus groups and surveys. We are also grateful for researchers helping to update a systematic review of recent papers on this topic.

Medically Assisted Dying (MAiD) and the Terminally Ill Adults Bill

RCPsych issued a briefing paper on the Terminally Ill Adults (End of Life) Bill for England and Wales prior to its third reading, raising serious concerns about the lack of safeguards for people with mental disorders, including eating disorders. The Faculty has contributed extensively to this process. You can read more about the College's response on page 8.

I have submitted evidence to the Parliamentary Committee as an individual clinician, drawing on collaboration with individuals with lived experience. I also represent our Faculty perspective on the MAiD working group. The Bill is due to be considered in the House of Lords after the summer recess, and we will continue to monitor developments closely.

CR170: updated guidance on adult ED services

Many thanks to all who supported the CR170 update. This comprehensive review reflects progress made since the original publication in 2012 and outlines key recommendations on:

- Workforce and training
- Digital innovation
- Risk and safeguarding
- Service models and access

The update incorporates learning from NICE, SIGN, NHSE and MEED guidance, as well as data from NHS benchmarking and Beat. It also includes a section on emerging clinical trends, including the impact of neurodivergence and gender diversity on ED care.

Please note that the accompanying patient and carer survey is temporarily paused while we focus on completing the LSED position statement.

Credentialing: building the future workforce

The second cohort of our credentialing programme is now well underway—thank you to all who have contributed as mentors and supervisors. I am in the process of handing over the lead role to Rachel Elvins, the Chair of the Eating Disorders Sub-Speciality Advisory Committee, and planning is already in motion for the October 2025 cohort.

We are currently recruiting new mentors—please do get in touch if you are interested in supporting this essential training initiative.

Thank you to our demitting executive members (2021–2025)

A heartfelt thank you to all Executive Committee members, including Helen Bould, Victoria Chapman and Ali Ibrahim, who are stepping down this year. You have served during an extraordinary period of change and challenge, including the pandemic, political uncertainty, and increasing demand for ED services.

Your leadership and contributions have been instrumental in shaping Faculty work across conferences, credentialing, policy development, and advocacy. We are enormously grateful for your time, dedication, and passion—and we hope to continue working with many of you in other College roles going forward.

Wishing you all a productive and fulfilling summer. As always, please feel free to reach out with ideas, feedback, or offers of collaboration.

Kind regards

Dr Agnes Ayton

Scottish personality disorder-eating disorder pathway update

As inpatient consultant on the North East Scotland Regional Eating Disorders Unit in Aberdeen, I have seen a rise over the past few years in patients being admitted with comorbid Eating Disorders and Personality Disorder. I have noted the apparent increase in the complexity of these patients; the high levels of patient distress caused by admissions; and the fact that, in my experience, specialist staff on the Eating Disorders Unit often do not feel sufficiently upskilled to look after patients with Personality Disorder. As a result, I began to have conversations locally about developing a pathway, to identify the aspects of care that were both helpful and unhelpful in this patient group. I soon found that these conversations had been replicated both regionally, and nationally, and, together with colleagues, we began to think about pathway development on a wider scale. Our first meeting was in April 2022, and focussed on Borderline Personality Disorder. This soon broadened out to the full range of personality disorders, and comorbid eating disorders.

Over the passing months, we have met regularly, taking time to establish the scope of the groups and the desired outcomes. We have tried to ensure a comprehensive coverage of clinicians from across Scotland, and from across disciplines, as well as representing the full age range. We have taken into account diversity of patients and have approached patient and carer representatives, as well as clinicians from General Practice and Medicine.

We decided that our desired outcome would be a pathway document. Given the limited evidence base, this would initially identify current practice across Scotland, and examine the available literature. We would hope to suggest what good practice would look like, and how this could be delivered in a Scottish context.

The hope would be that this would provide a baseline for future service development and be useful in planning and securing funding for this.

Early on in the process, we met for an afternoon workshop, where teams brought case vignettes. This allowed us to think about the commonalities and differences in patients that are being seen, but also in how the services respond. It was reassuring to experience far greater commonality than difference, and to learn from alternative perspectives.

This workshop will help us write anonymised case vignettes to be used in the document, to ensure that this is a “live” clinically relevant document, rather than simply prescriptive theory.

We have now divided into three work streams look at different aspects of the comorbid disorders. We are meeting regularly to discuss, write and edit. Speaking personally, there is huge benefit in these meetings on their own, as the shared experience and learning is significant.

We have links with the Scottish National Personality Disorder Improvement Plan, and aim to be represented in that.

We have also linked in with Dr Tony Winston, who is involved in similar work in England, and has been very helpful. It is also useful to have my involvement on the Faculty Executive Committee, so that we can link in with UK wide guidance and best practice, as well as national patient and carer representatives.

We have committed a significant amount of time to this project to date, and I feel that this is a worthwhile investment, from a clinician, patient and carer perspective.

Any queries and comments appreciated.

Louise Johnston

EmpowerED: embedding lived experience at the heart of eating disorder services

Dr Georgia Templeton

As a psychiatrist working in specialist eating disorder services in the North West of England, I’ve seen first-hand how involving Experts by Experience (EbEs) can fundamentally improve care. Some of my own patients now sit on the EmpowerED panel—a remarkable programme that is not only transforming services, but also transforming lives. Their involvement has increased confidence, given meaning to difficult experiences, and brought a sense of purpose. EmpowerED is part of the **Adult Eating Disorder Lead Provider Collaborative (LPC)** for the North West, and its approach to co-production is one of the most impressive I’ve encountered.

A New Model for Regional Collaboration and Commissioning
Lead Provider Collaboratives (LPCs) are designed to bring together NHS trusts to plan and deliver specialised services in partnership. The North West LPC for Adult Eating Disorders is led by **Cheshire and Wirral Partnership NHS Foundation Trust (CWP)**, working with:

- **Greater Manchester Mental Health NHS Foundation Trust**
- **Mersey Care NHS Foundation Trust**
- **Lancashire and South Cumbria NHS Foundation Trust**
- **The EmpowerED Commissioning Team**

The aim of the LPC is to reduce variation, improve outcomes, and bring patients closer to care. But at the heart of the North West's success lies EmpowerED—a team of Experts by Experience who help guide this work every step of the way.

EmpowerED: From Tokenism to True Partnership
EmpowerED is not just a consultation panel—it’s

a structural part of decision-making. I spoke with **Fiona Jenkins**, Head of Experts by Experience, who co-leads EmpowerED alongside Duncan Campbell and Gillan Faulkner. She described how the programme began with a partnership with BEAT and has grown into a fully embedded co-production structure.

"I didn't want their voices to sit on a shelf," Fiona told me. "We built a communications pathway where EbEs are equal partners—sitting on clinical delivery groups, operational groups, and the Partnership Board itself alongside chief executives and service directors."

From the start, Fiona and her team made a conscious effort to reach underrepresented communities. They attended 11 community events across the summer, including mosques and refugee centres, to ensure the panel reflects the diversity of the population. There are now **27 EmpowerED members and 7 pending applications**, with lived experience spanning across services in Cheshire, Merseyside, Lancashire, and Greater Manchester.

What Have EbEs Contributed?
The EmpowerED team have been involved in co-producing a range of initiatives, including:

- **The Healthcare Passport**, designed to ensure better communication of patient needs and preferences across services
- **Parallel**, championed and co designed by EbE's, a 12 week intensive step down service for patients leaving specialist eating disorder units
- **A new referral matrix**, reviewed and revised by EbEs to include crucial perspectives from carers and families
- **Admission pathways**, co-produced by EbEs including Molly and Tish, to ensure a more humane and person-centred experience

EmpowerED also supports quality assurance. EbEs attend service visits, giving honest feedback on patient experience and environment. One recent event brought together 15 EbEs in Warrington to share insights, build skills, and connect with one another—something described by attendees as both "healing" and "empowering."

"For many, it's part of their recovery," Fiona said. "They've lived through this 24/7. Their insights aren't just valuable—they're essential."

Supporting Experts by Experience: More Than Just a Role
What also stood out in my conversation with Fiona was the rigour of the process around recruitment, training, and safeguarding. Fiona draws on her previous experience in the police and third sector to ensure EbEs are well supported.

Each applicant completes a registration process via the EmpowerED website and undergoes DBS checks, a risk assessment, occupational health review, and a one-to-one onboarding session. The team makes sure EbEs are not only safe and ready to contribute—but that their wider skills and passions are recognised. Among the panel are academics, artists, dancers, writers, and former elite athletes.

"We don't just focus on the illness," Fiona explained. "We ask, what else do they bring? Who are they beyond the diagnosis?"

This strengths-based approach enables EmpowerED to match people to projects where their expertise shines. One current priority area is developing training for national sporting bodies, an issue that resonates personally for Fiona, who was once a national sprinting coach and athlete.

National Recognition and Influence
The success of EmpowerED has not gone unnoticed. Fiona now advises other regions looking to replicate the model, and the team regularly presents at national forums and events. Most recently, EmpowerED presented at the SIGN (Scottish Intercollegiate Guidelines Network) conference, sharing their approach to co-production and lived experience leadership.

Their work demonstrates how powerful, and necessary, it is to shift from consultation to genuine collaboration.

Reflections
From a clinician's perspective, EmpowerED offers not just good practice but best practice. It helps bring humanity into system-level thinking. It challenges us as professionals to listen differently, and it shows that recovery isn't just about treatment—it's also about having a voice, a role, and a community.

If you're interested in learning more, you can visit the EmpowerED section of the CWP website or listen to their growing podcast series, where EbEs reflect on their experiences of care and co-production.

In a system under pressure, EmpowerED is a reminder that innovation doesn't always come from the top, it can come from those who have walked the path themselves.

Dr Georgia Templeton

Consultant Psychiatrist in Eating Disorder Services.

Cheshire & Wirral Partnership.

Assisted death and eating disorders: learning from tragedies abroad

By Chelsea Roff and Bella Reed

As a parent of two survivors of anorexia and a researcher with lived experience of the illness, some might think we're overly anxious about what the Terminally Ill Adults (End of Life) Bill could mean for our community. After all, the Bill states that a person cannot be considered terminally ill "only" because of a mental illness, and anorexia nervosa is not generally considered terminal. But there are real reasons to fear this Bill could have devastating, life-ending consequences for people with eating disorders.

Anyone who has experienced or supported a loved one through anorexia knows its relentless highs and lows: periods of physical decline and weight restoration, profound depression and fragile hope, increasing social isolation and the return to oneself. For those of us who have lived through this, the thought of a loved one — or ourselves — being offered lethal medication during one of these low points is horrifying. Even after many years of failed treatments, recovery is possible, and it is in those despairing moments that we most need physicians to believe in us and our ability to heal.

In Belgium, the Netherlands, and the United States, at least 60 women with eating disorders have already died through physician-assisted death, with one-third in their teens or twenties (1). In some cases, physicians stated their eating disorders were "terminal," even though research shows nearly all medical complications of anorexia are reversible with proper care (2). Nearly half of these women had not received — or could not access — evidence-based treatments before their physician suggested death as an option. Most heartbreakingly, 58% of the patients reported suicidal ideation and 37% had previously attempted suicide.

The safeguards in this Bill are simply not robust enough to protect people with eating disorders. The bill's language, particularly its definition of terminal illness, leaves room for broad interpretation. The provision that someone cannot qualify for assisted dying "only" because of a mental illness is ambiguous and inadequate. Mental and physical illness are inextricably linked, and eating disorders often involve severe physical complications. In other countries, physicians have cited the physical complications of eating disorders — such as "terminal malnutrition" — to argue patients qualify as terminally ill (3). And, of course, if someone stops eating entirely, they will die, certainly within six months.

We also worry that families could be excluded from these decisions. Those of us who have been through anorexia or cared for loved ones know how important families are in advocating for treatment and holding on to hope when the person themselves cannot. Yet this Bill does not require families to be consulted, even when the doctor may be unfamiliar with the patient and the family might hold important information about their mental state or circumstances.

Canada, where assisted dying is now the fifth leading cause of death, provides a sobering example of how safeguards that sound robust in theory can fail in practice. Donna Duncan, a woman struggling with depression after a concussion, was euthanised just four hours after being released from a psychiatric unit, despite her daughters' objections that she was not terminally ill. Her decline had been exacerbated by months of delays in accessing proper treatment, but her request for euthanasia was approved in just four days. "It's unacceptable," her daughter told reporters. "It took a year to get treatment but only four days to die."

Many supporters of the Bill have used language to distinguish between assisted dying and assisted suicide, but let's be honest: this is about prescribing lethal drugs to help people end their lives. Suicide has historically been something our society — and psychiatry in particular — has worked to prevent. People take their lives when they are in despair, and that despair is often temporary and can be alleviated with proper medical, psychological, and social care. Legalising assisted suicide will create a two-tier system: one in which we work to prevent suicide for some while facilitating it for others.

Some may argue that if a person is suffering unbearably and wants to end their life, they should be allowed to commit suicide. But the core issue here is not whether individuals have the right to take their own lives; it is whether our healthcare system should institutionalise suicide as a medical practice. Respect for autonomy must be balanced with other ethical principles, like non-maleficence and beneficence. When a suicidal or self-harming patient is hospitalised, no one thinks it is appropriate to leave them alone with sharp objects to harm themselves further. We don't say, "The patient has a right to self-injure due to autonomy." Instead, we intervene to protect life.

We've already seen this erosion of suicide prevention measures abroad, where assisted death has become normalised for reasons solely related to a mental disorder. Framing suicide as a rational choice for some patients — even if that person has a serious, life-threatening illness — weakens the message that life can and should be preserved. This is especially concerning for eating disorder patients, whose suicidality is often linked to malnutrition. Psychiatry's role has always been to intervene and offer care and support to people in their darkest moments; we fear that legalising medical suicide will mean many patients are abandoned in their most desperate moments.

It's often said that people with anorexia are more prone to anxiety. Historically, parents of children with anorexia were dismissed as "over-anxious." But we are anxious about this Bill for good reason. There is a route out of anorexia: with nutritional rehabilitation, sufficient weight gain, and psychological interventions, recovery is possible. There is no route back from death.

1. Roff C, Cook-Cottone C. Assisted death in eating disorders: a systematic review of cases and clinical rationales. Frontiers in Psychiatry. 2024 Jul 30;15.

2. Westmoreland P, Krantz MJ, Mehler PS. Medical complications of anorexia nervosa and bulimia. Am J Med. (2016) 129:30–7. doi: 10.1016/j.amjmed.2015.06.031

3. Gaudiani JL, Bogetz A, Yager J. Terminal anorexia nervosa: three cases and proposed clinical characteristics. J Eat Disord. (2022) 10:23. doi: 10.1186/s40337-022-00548-3

(Westmoreland et al., 2023; Guarda et al., 2022).

College response to the Terminally Ill Adults (End of Life) Bill for England and Wales

In May 2025, the RCPsych provided a briefing for MPs and engaged extensively with media ahead of the Report Stage debate and Third Reading vote on the Terminally Ill Adults (End of Life) Bill for England and Wales. While the College did not, and does not, take a position on the principle of assisted dying, it stated that it could not support the Bill for England and Wales in its current form and provided nine reasons for this.

In June 2025, the Royal College of Physicians and Royal College of Psychiatrists sent a joint statement to all MPs on the Bill for England and Wales. This joint statement raised shared concerns and outlined the Bill's current deficiencies.

On 20 June, the Terminally Ill Adults (End of Life) Bill passed its Third Reading vote in the House of Commons. It has now gone to the House of Lords, where it has already had its First Reading.

The Second Reading in the House of Lords – which, unlike First Reading, will include debate from Peers and a vote on the Bill as amended in the Commons – is set to take place on Friday 12 September. If Peers choose to agree the Second Reading, the House of Lords Committee Stage is not expected to begin until October.

Additionally, Members of the Senedd will vote on a Legislative Consent Memorandum to indicate whether or not the Welsh Parliament gives its consent for the implementation of an assisted dying service in Wales should the Bill reach royal assent via the UK Parliament. If the Senedd does not agree to the legalisation then assisted dying could become legal in Wales but without a service made available by the state through the NHS. This vote will likely take place once there is a form of the Bill that is unlikely to change further. (This, then, will likely occur after Committee Stage in the Lords.)

The College has made formal representations at each stage of the parliamentary processes at Westminster and Cardiff Bay. It will continue to engage with policymakers as the Bill moves through the House of Lords and is scrutinised by the Senedd respectively, sharing our expert clinical insight to ensure the Bill has strong safeguards for people with mental illnesses, intellectual disabilities and autistic people, and to make sure the Bill is in line with the role and core duties of psychiatrists and other doctors, should it become law

Formulation-Based Health Assessments (FBHA): Moving away from protocol-based medical monitoring in eating disorders

Cambridgeshire and Peterborough
NHS Foundation Trust

Authors: Dr James Leaver (GP), Dr Charlotte Marks (GP), Minimol Sajith (Clinical Nurse Specialist), Dr Anna Conway Morris (Consultant Psychiatrist), Dr Fraser Arends (Consultant Psychiatrist)

Aim

To compare the impact of moving from a protocol-based medical monitoring approach to a formulation-based health assessment (FBHA) approach within an adult community eating disorder service.

Background

- **2019** - our medical monitoring (MM) service was commissioned to improve patient safety and reduce hospital admissions.
- **2021** - a local protocol was created to aid decision making. It used patient BMI, presence of purging symptoms and any electrolyte disturbance to determine the frequency of monitoring.
- **Nov 2023** - due to patient safety concerns and caseload management, we reviewed our practice. New guidelines implemented **Jan 2024**.

2023 review findings

- Frequent monitoring can enable eating disorder behaviours and/or encourage care seeking → **potential for iatrogenic harm**
- Clinician centred monitoring – driven by staff anxiety rather than individual patient's needs
- Endless monitoring of stable patients
- Unsafe caseload
- Risk of disengagement from primary care
- Term "medical monitoring" disempowers patients

Intervention

- If "stable", or risk of iatrogenic harm, we considered reducing FBHA frequency
- MDT working increased → inidividualised formulation-based decision making
- Focus on encouraging patient responsibility and respecting autonomy
- Home visits stopped
- Subjective data interpreted in the context of formulation, current symptoms and objective data
- Consultant psychiatrist led supervision for FBHA team
- Consultant led triage → right patient for the right service at the right time
- Complex discharge planning and collaboration with primary care

Method

We compared the number of appointments and number of patients having monitoring in 1 standard month during the protocol-based MM years and then the year after transitioning to an FBHA approach. We reviewed our acute admission data for one of our local hospitals over the last 5 years.

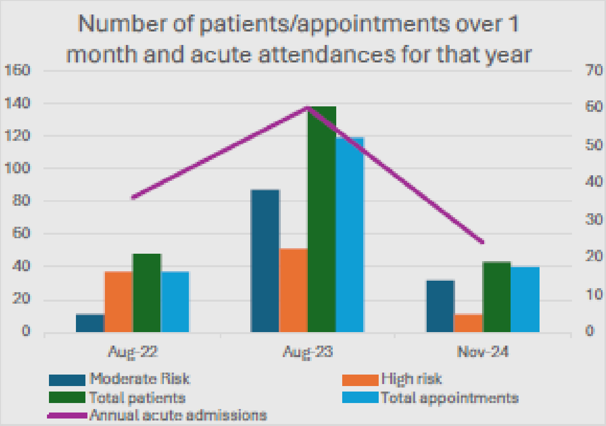
Results

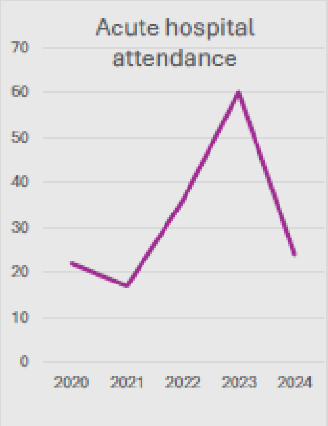
The 2021 MM protocol did not improve patient safety or reduce hospital admissions. Comparing August 2022 to August 2023 we saw:

- an **increase of 90 patients** being monitored
- **82 additional appointments** in one month
- annual **acute hospital attendance rise of 353%** from 17 in 2021 to 60 in 2023

After 1 year of adopting the FBHA approach:

- monthly medical appointments dropped from 119 to 40 **(66% reduction)**
- monthly number of patients being monitored fell from 138 to 43 **(69% reduction)**
- reduction in acute hospital attendances from 60 in 2023 to 24 in 2024 **(60% reduction)**
- Of the 21 patients who attended hospital in 2022-23, 16 **(76%) of them reduced their frequency of presentation to A&E in 2024.**





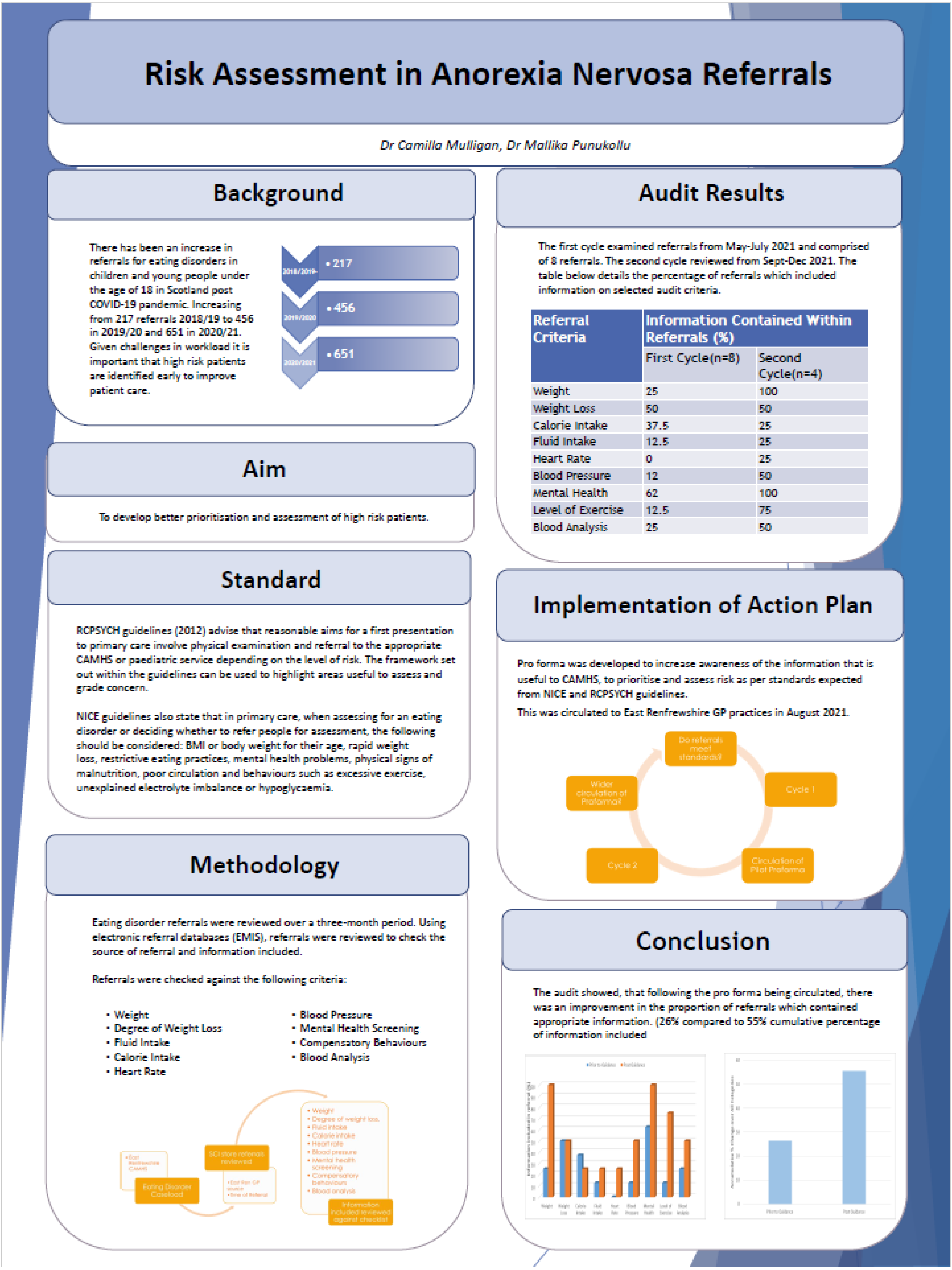
Conclusions

A protocol-based approach has potential to enable injurious behaviours and create dependency in eating disorder patients. It should not be considered a benign medical assessment to be undertaken by junior staff.

We suggest that FBHAs should be considered the gold standard approach to physical health monitoring in eating disorders as it gives experienced clinicians the flexibility to interpret data in the context of a patient's formulation.

The reduction in patients and appointments benefitted the service by allowing staff to gain experience across the wider service and enabled cross covering.

The complexity of decision making requires senior leadership, psychiatric oversight and experienced medical colleagues to work closely with the wider multi-disciplinary team. We understand this is not a model easily replicated across services nationwide.



Risk Assessment in Anorexia Nervosa Referrals

Dr Camilla Mulligan, Dr Mallika Punukollu

Background

There has been an increase in referrals for eating disorders in children and young people under the age of 18 in Scotland post COVID-19 pandemic. Increasing from 217 referrals 2018/19 to 456 in 2019/20 and 651 in 2020/21. Given challenges in workload it is important that high risk patients are identified early to improve patient care.

Aim

To develop better prioritisation and assessment of high risk patients.

Standard

RCPSYCH guidelines (2012) advise that reasonable aims for a first presentation to primary care involve physical examination and referral to the appropriate CAMHS or paediatric service depending on the level of risk. The framework set out within the guidelines can be used to highlight areas useful to assess and grade concern.

NICE guidelines also state that in primary care, when assessing for an eating disorder or deciding whether to refer people for assessment, the following should be considered: BMI or body weight for their age, rapid weight loss, restrictive eating practices, mental health problems, physical signs of malnutrition, poor circulation and behaviours such as excessive exercise, unexplained electrolyte imbalance or hypoglycaemia.

Methodology

Eating disorder referrals were reviewed over a three-month period. Using electronic referral databases (EMIS), referrals were reviewed to check the source of referral and information included.

Referrals were checked against the following criteria:

- Weight
- Degree of Weight Loss
- Fluid Intake
- Calorie Intake
- Heart Rate
- Blood Pressure
- Mental Health Screening
- Compensatory Behaviours
- Blood Analysis

Audit Results

The first cycle examined referrals from May-July 2021 and comprised of 8 referrals. The second cycle reviewed from Sept-Dec 2021. The table below details the percentage of referrals which included information on selected audit criteria.

Referral Criteria	Information Contained Within Referrals (%)	
	First Cycle(n=8)	Second Cycle(n=4)
Weight	25	100
Weight Loss	50	50
Calorie Intake	37.5	25
Fluid Intake	12.5	25
Heart Rate	0	25
Blood Pressure	12	50
Mental Health	62	100
Level of Exercise	12.5	75
Blood Analysis	25	50

Implementation of Action Plan

Pro forma was developed to increase awareness of the information that is useful to CAMHS, to prioritise and assess risk as per standards expected from NICE and RCPSYCH guidelines.

This was circulated to East Renfrewshire GP practices in August 2021.

Conclusion

The audit showed, that following the pro forma being circulated, there was an improvement in the proportion of referrals which contained appropriate information. (26% compared to 55% cumulative percentage of information included

Introduction to Hannah Hickinbotham

Lived Experience Representative at the Faculty of Eating Disorders

Host of the Full of Beans Podcast

Hi, I'm Hannah, the Eating Disorders Faculty Patient Representative and founder of the Full of Beans podcast. After navigating 14 years of recovery from atypical anorexia and body dysmorphia, I was recently diagnosed with AuDHD, and I have become passionate about challenging the assumptions that still exist around eating disorders, particularly in underrepresented presentations.

I launched Full of Beans five years ago to raise awareness, reduce stigma, and create a sense of connection for those struggling with eating disorders. Each week, I speak with people with lived experience, researchers, and clinicians to broaden understanding and provide hope, especially for those unable to access timely support.

Alongside this, I work with mental health professionals to strengthen their digital presence, through social media, websites, blogs, and email marketing, so they can reach and support more people online.

I'm deeply passionate about embedding lived experience into service design and research. I believe it's essential for creating compassionate, inclusive, and effective support systems for all. I like to act as the bridge between service users and clinicians, with the intention of bringing us all together to work on our united aim: to reduce the devastating impact eating disorders can have.

If you'd like to check out the podcast, here are a few episodes to get you started from a couple of names you might recognise:

A Clinician's Perspective of Severe and Enduring Eating Disorders and Palliative Care with Consultant Psychiatrist, Dr David Coyle
The Use of Creative Therapies with Eating Disorder Consultant Psychiatrist, Dr Louise Johnston

- Mentalisation-Based Treatment in Eating Disorders with Dr David Coyle
- Integrated CBT-E for Eating Disorders with Agnes Ayton

Feel free to drop me a message if you'd like to join me on Full of Beans too, I'm always happy to explore topics for future episodes!

You can also follow the podcast on Instagram @_wearefullofbeans!"