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National implementation of guided self-help family-based treatment for youth with eating disorders: a study protocol

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Abstract

Background Guided self-help family-based treatment (GSH-FBT) is emerging as a promising, more efficient alternative to traditional family-based treatment (FBT). The present study is designed to examine the real-world implementation of GSH-FBT at pediatric treatment sites across nine provinces in Canada.

Methods Implementation teams at each site consisting of a GSH-FBT coach, a medical provider, and a program administrator will be formed. Clinician coaches will be trained in this new modality and supported with weekly GSH-FBT consultation. Each site will recruit ten families with an adolescent with anorexia nervosa and the parents will undergo ten virtual GSH-FBT sessions. The implementation approach will be evaluated using qualitative and quantitative methods. Outcomes of interest include (1) treatment fidelity, (2) treatment wait times, (3) change in adolescent symptoms and parent/caregiver self-efficacy, (4) change in provider readiness, attitudes, and confidence towards the intervention, and (5) the overall experience of the implementation of the intervention from the perspective of the provider teams, and participant families.

Discussion The findings of this study will help to identify factors important to the acceptability and implementation of GSH-FBT in real-world clinical settings.

Trial registration This study was first registered with clinicaltrials.gov (registration # NCT06851273) on February 12, 2025 (url: https://clinicaltrials.gov/study/NCT06851273?id=NCT06851273&rank=1).

Keywords Adolescent, Anorexia nervosa, Eating disorders, Family-based treatment, Guided self-help, Intervention, Paediatric

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Text box 1. Contributions to the literature

- Anorexia Nervosa is notoriously difficult to treat. Treatments require significant time and resources and are often underfunded.
- Guided Self-Help Family-Based Treatment (GSH-FBT) updates the current gold-standard treatment, Family-Based Treatment (FBT), to require less time and fewer resources.
- Early findings point to similar outcomes for GSH-FBT and traditional FBT.
- The present study seeks to examine barriers and facilitators to real-world implementation of GSH-FBT in order to bring this treatment to as wide an audience as possible.

Background

Eating disorders (EDs) are amongst the most understudied illnesses affecting young women [1, 2]. EDs have their onset in early adolescence and affect up to 4% of adolescent girls in Canada [3] with 90% of ED sufferers being female [4]. Mortality rates for EDs are amongst the highest of all psychiatric illnesses [5]. Despite their high prevalence and mortality rates, a recent Australian report found that research funding for EDs is disproportionately low [1]. Specifically, only $2.05 research dollars were allocated per individual with an ED, with little investment in new treatment models. Comparatively, $19.56 were allocated per individual with depression, $32.11 for autism spectrum disorder, and $176.19 for schizophrenia [1]. A similar situation exists in Canada, where only $0.70 funding dollars were allocated per individual with an ED compared to $50.17 for schizophrenia [1]. This has prompted a call to action to improve research for youth with EDs [2].

Compounding the problem of research underfunding is the issue of healthcare system underfunding. The COVID-19 pandemic resulted in large increases in referral numbers [6] creating long waiting lists and fragmented care for children and youth with EDs, amplifying problems in the healthcare system that existed prior to the pandemic [7]. More efficient treatments are urgently needed to reduce wait times, especially given recent evidence indicating that being on a waiting list is a predictor of increased mortality for individuals with EDs [8].

The most widely used evidence-based treatment for children and adolescents with EDs is Family-Based Treatment (FBT) [9–11]. Traditionally, FBT involves 9–12 months of in-person manualized treatment, where a therapist guides a family in renourishing their child and a physician oversees the child's physical health [10]. Virtual adaptations of FBT (FBT-V) have been successful in maintaining key components of the intervention and producing similar patient outcomes to in-person FBT [12–14]. Similarly, Guided Self-Help FBT (GSH-FBT) is a virtual treatment, adapted using FBT principles, that involves a therapist "coach" and a video platform for parents [15]. There are reported challenges to delivering evidence-based treatments such as FBT with fidelity (meaning the treatment is delivered as true to the treatment model) [16, 17]. These challenges can be partially mitigated with a model, such as GSH-FBT, in which essential material is delivered by video or written material, standardizing the treatment and ensuring that key components are delivered. Guided Self-Help has recently been recommended for children, adolescents, and emerging adults with EDs in virtual care guidelines as a treatment of importance [18]; however, it is not widely available because it is a novel intervention.

The effectiveness of parental GSH-FBT for adolescents with anorexia nervosa (AN) was first reported within a feasibility study [15]. This study involved 19 families receiving 12 parent-only sessions lasting 20–30 min each conducted via phone or computer over a 6-month period. Median body mass index (BMI) increased significantly from 85% at baseline to 97% at the end of treatment. Eating-related psychopathology also improved. The dropout rate during treatment was 21%. These outcomes indicated that GSH-FBT was feasible and acceptable to families. Subsequently, a feasibility randomized controlled trial (RCT) comparing GSH-FBT to FBT delivered by videoconferencing (FBT-V) was published [19]. Using a Canadian-American sample (n = 19 from McMaster Children's Hospital and n = 21 from across the US), this intervention demonstrated feasibility, and clinical outcomes were very similar between GSH-FBT and FBT-V, with much greater efficiency in GSH-FBT as measured by changes in Eating Disorder Examination scores and Percent Expected Body Weight (%EBW). Qualitative perspectives from clinicians and parents on the intervention also indicate acceptability [20]. A large-scale RCT examining the effectiveness of GSH-FBT and FBT-V is currently underway in Ontario and the US. All of the effectiveness data show the promise of GSH-FBT. The present study aims to look at the effectiveness and acceptability of GSH-FBT in real-world conditions.

Methods

Study design

This study is a multi-site study funded by the Canadian Institutes for Health Research (NW2-196205). There will be one site in each of nine Canadian provinces: British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, Nova Scotia, and Prince Edward Island. Using a pre/post design [21], qualitative and quantitative methods will be used to study whether the GSH FBT implementation effort was effective. To implement this new model of care, one implementation team will be recruited at each of the nine study sites. Each implementation team will consist of a GSH-FBT coach, a medical provider, and a program administrator. These teams will meet initially with the research team

for implementation training and then at regular intervals for implementation consultation. Further, the study will include 90 adolescents (10 per site) aged 12–17 years with a diagnosis of Anorexia Nervosa per the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5 TR) [22]. All adolescents must live with their parents/guardians and be medically stable for outpatient treatment. All families will receive ten 20-minute virtual sessions of GSH-FBT over the course of six months.

Research questions

1) Does the implementation approach for GSH-FBT teams lead to implementation success at the participating sites, as measured by fidelity to the GSH-FBT model?
2) Does the implementation approach result in reduced wait times?
3) Do patients receiving GSH-FBT demonstrate improvement in symptoms?
4) Do GSH-FBT providers demonstrate change in readiness, attitudes, and confidence toward the intervention?
5) What is the experience of implementation teams, GSH-FBT providers, patients, and families with GSH-FBT and its implementation?

Participants

Adolescents

Inclusion criteria for this study are adolescents who (1) are between the ages of 12 and 17 years with a diagnosis according to DSM-5-TR criteria of AN or atypical AN, (2) are medically stable for outpatient treatment, (3) have a working computer with reliable internet access, and (4) speak and read English as do their parents/caregivers.

Adolescents will be excluded if they (1) have a current physical or psychotic or other mental illness that requires hospitalization and/or prohibits the use of psychotherapy, (2) have a current dependence on drugs or alcohol, (3) have a current physical condition known to influence eating or weight (e.g. diabetes mellitus, pregnancy), (4) have undergone four or more sessions of FBT for AN at any time, or (5) have an expected body weight (EBW) less than 75%. Lastly, when participants experience current, or report a history of, sexual or physical abuse by family members, perpetrators of the abuse will be excluded from treatment.

Providers

Administrators are program directors or managers and are responsible for ensuring that the coaches and medical staff have the time and resources needed to effectively carry out the GSH-FBT treatment. One administrator will be recruited at each site.

On average, three GSH-FBT coaches will be recruited at each participating treatment site. GSH- FBT coaches could come from a variety of disciplines provided they have experience in a mental health field and their professional college allows them to deliver the controlled act of psychotherapy.

Each site will also recruit one medical professional (physician, nurse practitioner, etc.) responsible for the medical management of adolescents with AN over the course of the study. The medical professional will also affirm that the adolescent is initially medically stable to enter the study at baseline.

This will yield an approximate sample size of 27 GSH-FBT coaches, nine medical practitioners, and nine administrators in this study.

Recruitment and study procedures

Implementation Team/GSH-FBT providers At each of the nine recruitment sites, the local principal investigator (LPI) will recommend individuals to join the implementation team consisting of one administrator, one GSH-FBT coach and one medical provider (MD or NP). Further coaches may also be recruited. These recommended individuals will be approached by the research assistants and asked to participate in the study. If these recommended practitioners decline to participate, further recommendations will be sought until the study roster is full.

All implementation team members and GSH-FBT coaches will be consented virtually by a member of the research team. They will provide demographics at baseline. They also will complete baseline, weekly, and end-of-treatment questionnaires virtually. At the end of the study, they will participate in a virtual interview.

Families/Adolescents Each site will recruit ten families to participate in this study. The individual sites will be responsible for recruiting, screening and consenting the families. Families and adolescents will complete baseline questionnaires and provide baseline demographics virtually. Parents/caregivers will receive an e-scale and will weigh the adolescent weekly. Parents/caregivers will attend ten sessions of GSH-FBT. At each session, they will provide their child's weight to the coach. Weight will be obtained using the e-scale provided to parents by the research team. At the end of treatment, parents and adolescents will again complete virtual questionnaires and they will all participate in a virtual interview.

This protocol has been approved by the Hamilton Integrated Ethics Review Board. It is under submission or being prepared for submission for the ethics review boards at the nine subsidiary sites.

Sample size considerations

Prior experience with the GSH-FBT model has indicated that recruitment has met targets in a feasible and reliable fashion. Regarding Research Question #1, this is descriptive in nature and a sample size cannot be calculated. For Research Question #2, a sample size calculation for wait times is challenging. There is currently no data available upon which to base a sample size calculation. For Research Question #3, change in symptoms of youth pre- and post- intervention will be examined, and for Research Question #4 change in provider readiness, attitudes, and confidence will be examined. A sample size calculation for paired t-tests (alpha = 0.05, beta = 0.2) for each measure was completed and found a range of eleven to 25 families needed, and a range of five to 11 providers needed, so this will be well within the recruitment estimates of 90 families and 27 providers. This will also allow an examination of site differences. For Research Question #5, the research plan is to recruit ten families per site (90 interviews) and nine implementation teams (9 focus group interviews comprised of 45 individuals). This large sample size for the qualitative interviews will also allow a comparison of themes across sites. A sample size calculation does not exist for qualitative research but is rather based on previous experience in the field, estimating when data saturation will occur [23, 24]. Thus, the research team is confident in their ability to answer the qualitative research question with this sample. Furthermore, it has been argued that saturation occurs within the first twelve interviews in a qualitative dataset [25]. Therefore, this sample should prove more than adequate.

The GSH-FBT intervention

Guided self-help FBT embodies all the principles of FBT, however, sessions with the therapist are viewed as coaching sessions in which parents are directed back to the video or reading material. It involves a 60-minute onboarding meeting and ten virtual 20-minute sessions involving only the parents over 3–6 months (this is one-third the time that an FBT therapist would provide). In GSH-FBT, weighing of the child occurs prior to the session by the parents, on the same day as the session. In GSH-FBT, parents have access to an online platform with a series of videos that outlines the core components of FBT: the urgency to act, parental empowerment, medical complications, strategies to use during and after mealtime, and how to externalize the illness. The video platform contains 73 short videos for parents to watch which are on average 7 min each. Homework is given at each session to either watch or review video material and/or read material from the book "Help Your Teenager Beat an Eating Disorder" [26].

Training and consultation in the GSH-FBT model

Workshop training for GSH-FBT providers and all members of the implementation team at each site will occur at the beginning of the study and will be led by members of the research team. The workshop training will include a focus on didactic material and a question-and-answer period. A training video and a GSH-FBT provider manual that has been developed and used within previous studies will be available to providers who are training in the model. There will be a section of training devoted to how administrators and medical providers can support the implementation within their respective roles. Ongoing consultation for GSH-FBT providers also led by members of the research team will occur biweekly in a group format with each site.

The implementation model

The current study is guided by the Quality Implementation Framework (QIF) [27]. The QIF provides a 14-step process to guide activities in four phases of implementation. This blended implementation approach using implementation teams, as well as intervention consultation, implementation consultation, and fidelity assessment has been applied in research by this team in eating disorder programs previously [14, 28]. The Standards for Reporting Framework for Implementation Studies [29] (StaRI) will guide both the methodology and reporting of findings.

Implementation procedures

Phase 1 - Initial considerations regarding the host setting

The implementation approach will follow the stages identified by the QIF [27]. Phase 1 site engagement and buy-in has been completed. Stakeholders in each province were identified and have committed to participating. Each of the GSH-FBT teams in the nine provinces involved will be asked to recruit at least ten families over the study period.

Phase 2 - Creating a structure for implementation: formation of implementation Teams, training, training evaluation and full-implementation preparation

Operational implementation teams will be developed at each site and include one program administrator, one GSH-FBT provider, and one medical provider—essential roles informed by the research team's prior implementation work [14]—who are all knowledgeable about the GSH-FBT model, as well as organizational processes and procedures affecting implementation. These teams will be responsible for the implementation of GSH-FBT, and their leadership at the organizational level is critical for effectiveness and sustainability. Members of the research team will meet virtually with all sites separately to formalize implementation team membership and discuss

Table 1 Schedule of assessments

Measures	Baseline	1	2	3	4	5	6	7	8	9	10 End of Treatment	End of Study
GSH-FBT Intervention	X – on boarding	X	X	X	X	X	X	X	X	X	X	
Fidelity Assessment		X	X	X	X	X	X	X	X	X	X	
Wait list Assessment	X											X
Height	X										X	
Weight	X	X	X	X	X	X	X	X	X	X	X	
Adolescent and Parent Measures	X										X	
Provider Measures	X											X
Qualitative Interview – Families											X	
Qualitative Interview - Sites												X

the implementation process. Implementation teams will then meet with the research team monthly to monitor the implementation process. Implementation teams will be asked at each meeting throughout the study to share what they consider to be important factors for GSH-FBT sustainment within their program over time and whether further GSH-FBT adaptations may be necessary, including any Equity, Diversity, and Inclusion (EDI) considerations. Implementation teams will also be encouraged to meet monthly away from the research team to independently manage their implementation plan. It is at this phase that the GSH-FBT training will occur.

Phase 3 - Ongoing structure once implementation begins: implementation of GSH-FBT in practice

Phase 3 is the period during which learning becomes integrated into provider and program practices and providers begin delivery of GSH-FBT with concomitant fidelity assessment. Implementation team members will continue to participate in monthly virtual meetings with the research team to discuss ongoing implementation issues and will meet monthly without the research team. Throughout Phase 3, the nine provincial sites will recruit, screen and consent families for the study. Providers will submit their video recordings of sessions which will be rated for fidelity by the research team. They will also submit self-ratings of fidelity. Providers will participate in biweekly virtual group consultation meetings led by members of the research team to troubleshoot general GSH-FBT issues. Guided Self-Help FBT providers will be encouraged to meet independently from the research team for peer consultation on a biweekly basis. Families will complete quantitative measures at baseline and end of treatment and will complete qualitative interviews at the end of treatment to elicit their perceptions of their experience receiving GSH-FBT.

Phase 4 - Improving future applications: evaluating the implementation experience

The evaluation phase of the implementation approach will involve the solicitation of feedback about the overall implementation process and a consideration of any further adaptations to the GSH-FBT model that may be necessary for sustained use over time. Implementation teams will continue to meet monthly without the research team and GSH-FBT providers will continue to meet on a biweekly basis for peer consultation without the research team at each site independently. One focus group interview will be completed at each organization, involving all of the GSH-FBT providers as well as the implementation team. Focus group interview questions will elicit experiences of the implementation process, perceptions about implementation success, and areas needing adaptation.

Measures

Please see Table 1 for a Schedule of Assessments.

GSH FBT provider fidelity

Fidelity assessment will be measured quantitatively using a fidelity instrument adapted for this purpose. This study will utilize a fidelity measure for GSH-FBT piloted in the team's previous feasibility RCT [19]. The fidelity measure is composed of the following nine binary yes-or-no items to assess GSH-FBT: (1) ensuring only parents are present; (2) ensuring the adolescent is not present; (3) asking parents about questions/comments regarding course materials; (4) avoiding direct orchestration of behavioural change; (5) referencing course materials during the session; (6) focusing the session on treatment; (7) assigning homework appropriately; and (8) & (9) verifying session length (See attached measures). Guided Self-Help FBT providers will submit video recordings of each session and will also complete a fidelity self-assessment evaluating their adherence to the principles of GSH-FBT outlined above. Provider demographics will be collected at implementation baseline (at the time of consent).

Wait list times

The administrator on each implementation team will be asked to provide (1) a wait time for services (in days) and (2) an estimate of the number of individuals waiting for child and adolescent ED services within their program

both at the time of enrollment in the study and at the end of study site focus group interview.

Adolescent measures

a) Eating Disorder Examination Questionnaire (EDEQ). The EDEQ is a 28-item standardized questionnaire that measures the severity of symptoms of EDs [30].
b) Beck Depression Inventory (BDI). The BDI is a 21-item questionnaire used to measure the severity of depressive symptoms [31].
c) Beck Anxiety Inventory (BAI). The BAI is a 21-item questionnaire used to measure the severity of anxiety symptoms [32].
d) Yale-Brown-Cornell Eating Disorder Scale (YBC-EDS). The YBC-EDS consists of 19-items to assess impairment, persistence and degree of obsessional thinking and compulsiveness about eating behaviors [33, 34].
e) Yale-Brown Obsessive-Compulsive Scale-II-Self Report (Y-BOCS-II-SR): The Y-BOCS-II-SR is a questionnaire assessing obsessions and compulsions separate from the eating disorder. It queries 29 obsessions and 53 compulsions. There are two 5-item sections assessing the severity and degree of interference of the obsessions and compulsions 35, 36]. The Y-BOCS has been used previously with children [37].

Parent/caregiver measures

a) Parents versus Eating Disorder Scale (PvED) is a 7-item measure assessing parental self-efficacy related to re-feeding their child with an ED [38, 39].

GSH FBT provider measures

a) Brief Individual Readiness for Change Scale (BIRCS) [40] is a 5-item scale examining provider individual readiness for change.
b) Evidence Based Practice Attitudes Scale (EBPAS) [41] is a measure of provider attitudes about evidence-based practice.
c) Perceived Attributes of the Principles of Effectiveness Scale (MPAQ) [42] is an adapted version of the scale assessing confidence related to the intervention.

Qualitative interviews

The experience of GSH-FBT teams, providers and families across settings will be evaluated qualitatively using fundamental qualitative description [43]. Implementation teams (n = 9) at each site will undergo a virtual semi-structured focus group interview at the end of the study period with a research assistant. This interview will also include any providers of GSH-FBT at that site as well, resulting in five participants at each site (three GSH-FBT providers, one medical provider and one administrator). These qualitative evaluations will focus on the execution of the implementation process, and the overall success of the implementation, as well as any perceived barriers. They will also examine satisfaction with the intervention, factors for the sustainability of the intervention, as well as Equity, Diversity and Inclusion (EDI) considerations in terms of individual, interventional, organizational, and systemic factors thought to be important for implementation. Families will also participate in a qualitative focus group interview after their final GSH-FBT session to share their experience of the intervention (n = 10 at each site for a total of 90 interviews). Although youth will not be present to directly interact with the coach, the research team is interested to hear their impressions. A similar process of videorecording, transcription, and analysis will occur for site and family focus group interviews.

Analysis

Research question #1: The percentage of providers demonstrating fidelity to the GSH-FBT model will be determined by a fidelity rating scale achieving a 7/9 (80%) average score or greater on each session. Provider demographics will be examined related to implementation success.

Research Question #2: A pre- and post-analysis of wait times and number of individuals waiting will be completed using a paired t-test analysis.

Research Question #3: Pre- and post- mean scores will be compared using paired t-tests. Significance will be set at a p value of 0.05. Demographics will be examined in relation to outcome.

Research Question #4: Pre- and post- mean scores will be compared using paired t-tests. Significance will be set at a p-value of 0.05. Provider demographics will be examined in relation to outcome.

Research Question #5: Transcripts from focus groups will be analyzed using conventional content analysis and the constant comparison technique [44]. Specifically, iterative reviews of text within and across transcripts will be completed by two members of the research team in order to identify the salient themes characterizing the provider, implementation team, and family experience with GSH-FBT, their suggestions for change (if any), and to provide a rich description of their perceptions of the value and impact of the GSH-FBT model. We will also examine site differences.

Discussion

This study seeks to address the need for efficient treatments for youth with EDs. The promise of GSH-FBT lies in its brevity – approximately one third of the length of traditional FBT – and the convenience of its virtual setting for both clinician training and treatment delivery. The research aims are particularly important to community and healthcare stakeholders, as findings can be directly applied in their roles supporting, managing and caring for this population.

An advantage of this study is its broad reach. Given that the present study has participation from across Canada and includes both major hospitals and smaller community health agencies, the heterogeneity of the population under study will allow for the collection of a rich array of data. This includes learning about the experience of GSH-FBT implementation for a variety of site teams across the nation as well as the effectiveness of GSH-FBT treatment on the study population. Additionally, with such wide-ranging participation, the demographics of the sample will hopefully reflect the variability found in Canada. Further, collaborators will be able to disseminate study findings rapidly to other relevant stakeholders locally, provincially, and nationally.

One of the largest challenges currently being faced in this study is the procurement of ethics approval in multiple provinces. Initially, the research team proposed to centralize recruitment, screening, and consent meetings using email, telephone, online questionnaires, and Zoom meetings out of a desire to minimize the burden placed on the treatment sites across the country. However, since the treatment will be provided locally, the central ethics board suggested that recruitment, screening, and consent procedures should occur locally at each site, thus requiring ethics approval within each province. This requires the research team to develop nine individualized recruitment, screening, and consent procedures with accompanying documentation and data tracking procedures. This will add to the time delay in initiating the study.

The recruitment of a medical provider for the implementation team at several sites is an additional challenge encountered by the research team. Due to staffing shortages or other professional obligations, some sites were unable to supply their own medical provider for the implementation team. To ameliorate this concern, it was decided that patients recruited from this site would rely on individual family physicians for medical monitoring throughout the study and implementation team meetings would continue without a dedicated medical provider. Furthermore, due to the small staff at many of the provincial sites, the local principal investigator, at times, also will act as a member of the implementation team.

One limitation of the present study is that the materials are available in English only. This could potentially limit the participant pool to a smaller range of participants; eliminating, for example, those who speak only French, and those who have more recently immigrated. If the findings indicate that GSH-FBT is effective, efficient, and acceptable, translation of treatment materials into other languages would be a potentially valuable avenue for future research. Furthermore, at least two of the provincial sites usually conduct research in both French and English. Canada has two official languages (English and French) and it is hoped that if this study shows acceptability and feasibility that the intervention could be translated into French for this segment of the Canadian population.

Equity, diversity and inclusion (EDI) considerations are also a topic of interest in the present study. Identification and referral of individuals with EDs from equity-deserving populations (Indigenous, Black and other racialized youth as well as 2SLGBTQIA + youth) have traditionally been issues within the ED field, where these populations are underrepresented in clinical research and treatment despite the prevalence of EDs being equal or greater within these groups [45]. Poor recognition of EDs amongst equity deserving populations by clinicians is one of the main reasons cited for this underrepresentation, perhaps due to the stereotype of EDs only affecting white, affluent females [46]. Help-seeking behaviour might also be culturally mediated, with some equity deserving populations stating that stigma and social stereotyping are even more significant in their culture [47, 48]. Further, it is known that experiences of racism, transphobia and homophobia are cited as reasons that various equity deserving populations avoid seeking formal medical care [49, 50]. A future consideration might be concordance of families and GSH-FBT providers given evidence that concordance between patients and providers in other healthcare settings improves outcomes [51, 52] and can have a large impact on comfort and rapport [53]. This will be queried directly in our qualitative interviews.

In conclusion, this research will gather valuable information on how to best implement GSH-FBT, a novel and efficient treatment, across Canada in a variety of healthcare settings. It is anticipated that GSH-FBT will be successfully implemented in these various health care settings resulting in reduced wait times and greater access to care. The results of this study have the potential to be further scaled up to community providers in remote areas. A large number of healthcare providers across Canada have committed to collaborating on this project, indicating that access to care for youth with EDs remains a barrier to patients and families across Canada. With teams participating in nine provinces in Canada in this project, it has the potential to be highly impactful in changing the way services are delivered, allowing

more individuals with EDs to have timely and effective treatment.

Abbreviations

AN	Anorexia Nervosa
BAI	Beck Anxiety Inventory
BDI	Beck Depression Inventory
BIRCS	Brief Individual Readiness for Change Scale
BMI	Body mass index
DSM-5-TR	Diagnostic and Statistical Manual of Mental Disorders
EBPAS	Evidence Based Practice Attitudes Scale
EBW	Expected body weight
ED	Eating disorder
EDEQ	Eating Disorder Examination Questionnaire
EDI	Equity, diversity and inclusion
FBT	Family-based treatment
FBT-V	Virtual family-based treatment
GSH-FBT	Guided self-help family-based treatment
LPI	Local principal investigator
MPAQ	Perceived Attributes of the Principles of Effectiveness Scale
PvED	Parents versus Eating Disorder Scale
QIF	Quality Implementation Framework
RCT	Randomized controlled trial
StaRI	Standards for Reporting Framework for Implementation Studies
Y-BOCS-II-SR	Yale-Brown Obsessive-Compulsive Scale-II-Self Report
YBC-EDS	Yale-Brown-Cornell Eating Disorder Scale

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Author contributions
JC – Conceptualization, Methodology, Writing – Original Draft, Writing – Review and Editing, Supervision, Funding Acquisition: JS & JDL – Conceptualization, Funding Acquisition, Writing – Review & Editing: MN1 – Project Administration, Resources, Writing – Review & Editing: TY & EN – Writing – Original Draft, Writing, Review & Editing: HA, SA, JB1, JB2, JSC, AC, ND, GD, CF, LI, NJ, SJ, DK, BK, AK1, MK, SK, AK2, EL, AM, BM1, GM, BM2, MN2, NO, SP, WP, AR, SS, CS, WS, CW, JW – Writing – Review & Editing.

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Data availability
No datasets were generated or analysed during the current study.

Declarations

Ethics approval and consent to participate
Ethics approval was obtained from the Hamilton Integrated Research Ethics Board (HiREB). All human participants will provide informed consent prior to participation.

Competing interests
The authors declare no competing interests.

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