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CADTH Health Technology Review Early Intervention Programs for Adolescents and Young Adults with Eating Disorders – Supporting Information

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Health Technology Assessment



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Abbreviations

AN	anorexia nervosa
BDI-II	Beck Depression Inventory-II
BED	binge eating disorder
BMI	body mass index
BN	bulimia nervosa
CAPS	Child and Adolescent Perfectionism Scale
CBT	cognitive behavioural therapy
CBT-P	cognitive behavioural therapy for perfectionism
CEA	cost-effectiveness analysis
CI	confidence interval
CIA	Clinical Impairment Assessment
CORE-10/OM	Clinical Outcomes in Routine Evaluation-10/Outcome Measure
DASS-21	Depression, Anxiety and Stress Scale-21
DSM	Diagnostic and Statistical Manual of Mental Health
DUED	duration of untreated eating disorder
DUSC	duration of eating disorder onset to specialist contact
EBW	expected body weight
ED	eating disorder
EDE-Q	Eating Disorder Examination Questionnaire
EDI	Eating Disorder Inventory
FBT	family-based treatment
FT	family therapy
FREED	First Episode and Rapid Early Intervention in Eating Disorder
GOAS	Global Outcome Assessment Schedule
НоТ	home therapy
IQR	inter-quartile range
LEE	Level of Expressed Emotion
М	mean
MD	mean difference
MROC	Morgan and Russel Outcome Categories
MROAS	Morgan-Russel Outcome Assessment Schedule
Ν	number
NR	not reported



OSFED	other specified/unspecified feeding and eating disorder
PSYCHLOPS	Psychological Outcome Profile
RCT	randomized controlled trial
ROB	Risk of Bias
ROB2	Risk of Bias Tool for Randomized Trials Version 2
ROBINS-I	Risk of Bias in Non-randomized Studies – Interventions
RR	rate ratio
SAS	Social Adjustment Scale
SCL-90-R	Symptom Check List 90-Revised
SD	standard deviation
SE	standard error
TAU	treatment as usual
WSAS	Work and Social Adjustment Sale



Amendments and Deviations From the Protocol

Table 1: Amendments and deviations from the protocol

Section	Amendment or Deviation	Page Number in Protocol	Rationale
Patient Engagement	Specific details of engagement activities were not delineated in the protocol. Further details about participant selection and engagement activities are described in Patient Engagement Methods below.	7	The protocol did not address the specific patient engagement activities that would be conducted, therefore further details are supplied in Patient Engagement Methods below.
Clinical Effectiveness and Clinical Harms	Rather than having 2 reviewers conduct the clinical review (i.e., data extraction, critical appraisal, data analysis), a single reviewer was responsible for the clinical review thus altering the study design from a systematic review to a rapid review, except for study selection which involved 2 reviewers agreeing on their decisions to include or exclude each study screened. With this change, the literature search methods were also streamlined, updating the database searches monthly (initial search conducted on May 24, 2023 and last alert completed on August 24, 2023) but not the grey literature search (conducted once from May 25 to June 5, 2023).	13,14, 15, 19 to 22	The study design and approaches to data extraction, critical appraisal, and data analysis was modified due to feasibility and resourcing constraints.
	No attempt was made to quantitatively synthesize the data from the findings via meta-analyses.	21	The data from the findings was deemed too heterogenous to appropriately pool and provide a quantitative synthesis.
	Rather than posting a list of studies selected for inclusion on the CADTH website for broad feedback, the list was sent to a group of select external stakeholders for targeted feedback.	19, 32	The targeted feedback approach was used due to feasibility and resourcing constraints during the data selection phase.
	Outcome-level risk of bias assessment for the critical appraisal was not done. Instead, an overall assessment of study risk of bias from the domain level was used to inform the critical appraisal of included studies.	20	This change is in line with the approach used in CADTH's rapid reviews, which was used to guide the clinical review.
Health Economics: Health care resource implications	Rather than consulting with program administrators and clinical experts, CADTH identified the health care resources needed for implementing and running an early intervention program for eating disorders through a review of the literature. This included a grey literature search for existing programs in Canada and review of their descriptions, as well as a review of relevant articles that were identified via the clinical	17	The approach to identifying the resources needed to implement or run an early intervention program for eating disorders was modified due to feasibility concerns and to avoid potential delays to obtaining the information.



Section	Amendment or Deviation	Page Number in Protocol	Rationale
	and economic reviews for descriptions of the components of the interventions assessed within those studies.		
Social and Ethical Dimensions	This section of the project was removed.	25 to 32	This change was due to resourcing constraints.

Patient Engagement Methods

Participant Selection

Five individuals were selected to participate in an initial engagement dialogue with CADTH staff: 3 with direct lived experience, 1 caregiver of a youth, and 1 dietician who specializes in working with individuals with eating disorders. Identified individuals had diverse backgrounds, experiences, and lived in different geographic regions across Canada. Some self-identified as members of communities that experience marginalization. One individual had experience of seeking initial services during the coronavirus pandemic, while the others' experience was before the pandemic. One potential advisor with lived experience withdrew after an initial introductory call due to scheduling conflicts.

Several other individuals were identified as potential participants for a group consultation during the Stakeholder Feedback period after the draft report has been completed. They were contacted at the conclusion of the draft report for further engagement. They also bring diverse experiences of treatment and are located across Canada.

Engagement Activities

Individual Dialogues

The 4 identified advisors were invited to participate in a dialogue facilitated by a CADTH Patient Engagement Officer and attended by 1 or 2 Research Officers on the project team. There was 1 dialogue without Research Officers in attendance due to scheduling conflicts, but the recordings and summaries were available afterwards for their information. The purpose of attending the dialogues is for members of the project team to hear directly from people with lived experience and have the opportunity to ask questions relating to what they have read in the literature. Participants were able to share their unique experiences as well as perspectives gained through their interactions with other individuals with experience of treatment for eating disorders. These dialogues occurred between June and August 2023, during the drafting phase of the report.

With consent, the dialogues were recorded for the purposes of notetaking and sharing with additional members of the project team. The Patient Engagement Officer subsequently drafted short summaries of each discussion, and each participant had the opportunity to revise and adapt their summary. Summaries were disseminated to members of the CADTH project team to enhance their understanding of the perspectives and priorities shared in the dialogues.



Stakeholder Feedback

Per standard CADTH process, the draft report was released to the public for a 10-day Stakeholder Feedback period. Members of the public, including individuals with lived experience, patient groups, and clinicians, had an opportunity to review and submit their written feedback on the findings of the report.

Group Consultation

Eight interested individuals, including those who participated in dialogues, were invited to a group consultation during the Stakeholder Feedback period after the draft report was released to the public. Four individuals agreed to participate, 3 with direct experience of an eating disorder and 1 caregiver of a youth, with 1 individual withdrawing due to illness. Individuals were provided with a link to the draft report and invited to participate in a Zoom call. Participants reviewed the key themes and had the opportunity to comment on the report. Their comments were reviewed with the feedback received during the Stakeholder Feedback period, and adjustments were made to the report as appropriate.



Selection of Included Clinical Studies





Summary of Included Clinical Studies

Table 2: Characteristics of Included Clinical Studies

Authors (year), study design, country, funding source	Relevant participant characteristics	Intervention and comparator(s)	Relevant clinical outcomes (measurement)	Length of follow-up	
Early Intervention Program Studies					
Richards et al., (2023) ¹ Pre-post cohort study	Inclusion criteria: Participants aged 16 to 25 with an ED diagnosis of < 3 years duration	Intervention: FREED service model • FREED-4-All cohort	Adherence to wait time targetsED symptomology	 FREED-4-All cohort: changes between pre-treatment and post-treatment (over 	

Authors (year), study design, country, funding source	Relevant participant characteristics	Intervention and comparator(s)	Relevant clinical outcomes (measurement)	Length of follow-up
UK Academic Health Science Network National Programme; Health Foundation; NIHR Biomedical Research Centre at South London and Maudsley NHS Foundation Trust and King's College London; NIHR Senior Investigator Award; NHS Innovation Accelerator Fellowship	Participant characteristics: Sample size: • FREED-4-All cohort, n = 2473 • FREED-Up cohort, $n = 278$ Age, mean (SD): • FREED-4-All = 19.87 (2.29) • FREED-Up = 20.19 (2.39) Gender: NR ED Diagnosis, % (n): • FREED-4-All ($n = 1779$) ^a • AN = 46% (819) • BN = 25% (450) • BED = 4% (67) • ARFID = 1% (22) • OSFED = 24% (421) • FREED-Up ($n = 278$) • AN = 35% (96) • BN = 27% (75) • BED = 1% (3) • ARFID = 0% (0) • OSFED = 37% (104) DUED, mean (SD): • FREED-4-All = 14.86 (9.73) • FREED-Up = 17.85 (10.38)	represents the most recent cohort of FREED participants. • FREED-Up cohort represents a past cohort of FREED participants included in a multi-site study. Comparator: NA (single- arm pre-post analysis on FREED-4-All and FREED-Up cohorts)	(EDE-Q) Binge eating, vomiting, laxative episodes (behavioural items from EDE-Q) Change in BMI Psychological distress (CORE-10/ OM)	unspecified duration) • FREED-Up cohort: changes between baseline to 3-, 6-, and 12-month follow-up
Austin et al., (2022) ² Retrospective cohort study UK Health Foundation	Participant data was extracted from the FREED-Up study (see Flynn et al., [2020] for inclusion/exclusion criteria and participant characteristics)	Intervention: FREED service model ^a Comparator: TAU cohort ^b	 ED symptomology (EDE-Q) Psychological distress (CORE-10) Psychological impairment due to ED (CIA) Change in mood (DASS-21) Functional 	• Baseline to 3-, 6-, and 12-month follow-up



Authors (year), study	Relevant participant	Intervention and	Relevant clinical	
funding source	characteristics	comparator(s)	(measurement)	Length of follow-up
			 impairment due to ED (WSAS) Perception of emotion for caregiver or partner (LEE) Function and wellbeing (PSYCHLOPS) Change in BMI 	
Radunz et al., (2021) ³ Single-arm pre-post cohort study Australia Funding: NR	Inclusion criteria: Participants aged 16 to 25 with ED symptoms for < 3 years who accessed treatment in one of two clinics servicing South Australia (n = 96) Participant characteristics: Age, M (SD); min, max = 19.3 (2.39); 16, 26 Gender (female), % = 92%	Intervention: Early intervention services for ED in "emerge-ED" program which provides tailored treatment (e.g., CBT) to service users within pre-specified wait time targets Comparator: NA (single-arm pre-post intervention analysis)	 ED cognitions and behaviours (ED-15) ED symptomology (EDE-Q) Psychosocial impairment (CIA) Depression, anxiety and stress (DASS-21) Change in BMI 	Baseline to end of treatment (approximately 6 months in duration)
Richards et al., (2021) ⁴ Pre-Post cohort study UK Shine and Scaling Up Improvement Award from the Health Foundation (GIFTS 7294/CRM 1216); PhD studentship from the Health Foundation; King's College London International Postgraduate Research Scholarships; NHS Innovation Accelerator Fellowship; NIHR Biomedical Research Centre for Mental Health, South London and Maudsley NHS Foundation Trust and Institute of Psychiatry,	Participant data was extracted from the FREED-Up study (see Flynn et al., [2020] for inclusion/exclusion criteria) Participant characteristics from FREED cohort included in the FREED-Up study (n analyzed = 259)°: Age, M (SD) = 20.19 (2.34) Gender, female:male = 241:18 Ethnicity, n (%): • White = 170 (66%) • Asian = 25 (10%) • Black = 10 (45%) • Mixed = 19 (7%) • Other/unknown = 35 (14%)	Intervention: FREED service model ^a Comparator: TAU cohort ^b	Program fidelity (adherence to wait times)	NA



Authors (year), study design, country, funding source	Relevant participant characteristics	Intervention and comparator(s)	Relevant clinical outcomes (measurement)	Length of follow-up
Psychology and Neuroscience at King's College London; NIHR Senior Investigator Award	Baseline EDE-Q score, M (SD) = 4.06 (1.23)			
Flynn et al., (2020) ⁵ Pre-Post cohort study UK Health Foundation; Scaling Up Improvement Award	 Inclusion criteria: FREED cohort (from which FREED-Up cohort [i.e., past FREED participants included in a multisite study] was derived): participants aged 16 to 25 who had a primary diagnosis of ED and < 3 years duration of illness TAU cohort: participants aged 16 to 25 with an ED illness duration of < 3 years who accessed ED services approximately 1.5 to 2 years before the implementation of FREED Exclusion criteria: Participants in need of immediate in-participant admission, a primary comorbid physical or mental disorder, severe intellectual disability, and insufficient English language to complete study procedures Participant characteristics: Sample size FREED-Up cohort (n = 278) TAU cohort (n = 224) Age, M (SD): FREED-Up = 20.19 	Intervention: FREED service model ^a Comparator: TAU cohort ^b	 ED onset, duration, frequency, and severity (DUSC, DUED) Wait times (weeks) Treatment uptake 	NA

Authors (year), study			Relevant clinical	
design, country, funding source	characteristics	comparator(s)	outcomes (measurement)	Length of follow-up
	• TAU = 20.28 (2.43)			
	Sex, female:male:			
	 FREED-Up = 259:19 			
	• TAU = 216:8			
	ED diagnosis, n (%):			
	FREED-UP			
	∘ AN = 117 (42.1%)			
	∘ BN = 71 (25.9%)			
	∘ BED = 3 (1.1%)			
	 OSFED = 86 (30.9%) 			
	• TAU			
	• AN = 116 (51.8%)			
	• BN = 59 (26.3%)			
	• BED = 6 (2.7%)			
	 OSFED = 44 (19.6%) 			
	Ethnicity, n (%):			
	 FREED-Up 			
	• White = 181			
	(65.1%)			
	• Asian = 27 (9.7%)			
	• Black = 11 (4.0%)			
	• Mixed = 20 (7.2%)			
	 Unknown = 39 (14.1%) 			
	• TAU			
	 White = 174 (77.7%) 			
	∘ Asian = 21 (9.4%)			
	∘ Black = 5 (2.2%)			
	 Mixed = 7 (3.1%) 			
	 Ouknown = 17 (7.6%) 			
Fukutomi et al., (2019) ⁶	Participant data was extracted from the	Intervention: FREED service model ^a	 24-month service utilization 	Baseline to 24-month follow-up
Pre-Post cohort study UK	FREED pilot study (see McClelland et al., [2018]	Comparator: TAU cohort ^b	 Last measured BMI 	
NIHR; The Health	criteria) but only			
Foundation	included participants diagnosed with AN			
	Participant characteristics:			



Authors (year), study design, country, funding source	Relevant participant characteristics	Intervention and comparator(s)	Relevant clinical outcomes (measurement)	Length of follow-up
McClelland et al	Sample size: • FREED-AN cohort (n = 22) • TAU-AN cohort (n = 35) Age (combined), M = 20.4 EREED cohort (from	Intervention:	• Wait times (weeks)	Receive to 2- 6- and
(2018) ⁷ Pre-Post cohort study UK NIHR Health Foundation	 which FREED pilot cohort [i.e., past FREED participants included in a multi-site study] was derived): Inclusion criteria: FREED cohort = participants aged 18 to 25 with a primary ED diagnosis and < 3 year duration of illness TAU cohort = participants aged 18 to 25 with an ED illness duration of < 3 years who accessed ED services 2 years before the implementation of FREED Exclusion criteria: Participants in need of immediate in-participant admission, a primary comorbid physical or mental disorder, inability to participant for 12-month duration of study, and insufficient English language to complete study procedures Participant characteristics: Sample size: FREED cohort (n = 56) TAU cohort (n = 86) 	FREED service model ^a Comparator: TAU cohort ^b	 Treatment uptake Change in BMI ED symptomology (EDE-Q) Change in mood (DASS-21) Psychological impairment due to ED (CIA) Perception of emotion for caregiver or partner (LEE) Psychological distress (CORE-10) Work and social adjustment impairment 	12-month follow-up

Authors (year), study design, country, funding source	Relevant participant characteristics	Intervention and comparator(s)	Relevant clinical outcomes (measurement)	Length of follow-up
	Age at referral, M (SD): • FREED = 20.4 (2.24) • TAU = 20.4 (2.0) Age of illness onset, M (SD): • FREED = 19.3 (2.6) • TAU = 19.3 (2.1) Gender, female, n (%): • FREED = 54 (96%) • TAU = 85 (98%) Diagnosis, n (%): • FREED: • AN = 22 (35%) • BN = 18 (32%) • BED = 1 (2%) • OSFED = 15 (27%) • TAU: • AN = 35 (40%) • BED = 4 (5%) • OSFED = 23 (27%)			
Brown et al., (2016) ⁸ Pre-Post cohort study UK Shine award from the Health Foundation); NIHR Biomedical Research Centre for Mental Health, SLaM and Institute of Psychiatry, Psychology and Neuroscience, King's College London	 Inclusion criteria: FREED cohort = participants aged 18 to 25 with a primary ED diagnosis and < 3 year duration of illness TAU cohort = participants aged 18 to 25 with an ED illness duration of < 3 years who accessed ED services 2 years before the implementation of FREED Exclusion criteria: Participants in need of immediate in-participant admission, a primary comorbid physical or mental disorder, severe 	Intervention: FREED service model ^a Comparator: TAU cohort ^b	 DUSC DUED Wait times (weeks) Treatment uptake 	NA

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Authors (year), study	Delevent neuticinent		Relevant clinical	
design, country, funding source	characteristics	comparator(s)	(measurement)	Length of follow-up
	learning disability Participant characteristics: Sample size: • FREED cohort (n = 51) • TAU cohort (n = 89) Age, M (SD): • FREED = 20.64 (2.52) • TAU = 20.47 (1.99) Gender, female, %: • FREED = 49:2 • TAU = 87:2 Diagnosis, n (%): • FREED • AN = 20 (39.2%) • BN = 17 (33.3%) • OSFED = 14 (27.5%) • TAU • AN = 33 (37.9%) • BN = 25 (28.1%) • OSFED = 25 (28.1%) • No ED = 2 (0.02%)			
	Studies of Interv	ention Programs at the Ear	lv Phase of Illness	
Godart et al., (2022) ⁹ Long-term follow-up analysis of an RCT France Projet Hospitalier de Recherche Clinique (CRC-PHRC, 1997, AOM97133 APHP, French Ministry of Health), the Caisse Nationale d'Assurance Maladie des Travailleurs Salaries (CNAMTS), and the Fondation de France	See Godart et al., (2012) for inclusion/exclusion criteria and participant characteristics	Intervention: Systematic family therapy in combination with a multidisciplinary outpatient care program Comparator: TAU multidisciplinary outpatient care program	 Change in BMI AN clinical functioning (GOAS) ED psychological and behavioural traits (EDI) Psychological distress and/or psychological status (SCL-90-R) Family adaptability and cohesion (FACES III) 	Baseline to 6-, 12-, 18-, and 54-month follow-up
Pre-post cohort study	Participants between the ages of 12 and 18	Home-based treatment post inpatient treatment	 Change in BMI ED-specific psychopathology 	end of treatment and 1-year follow-up



Authors (year), study design, country, funding source	Relevant participant characteristics	Intervention and comparator(s)	Relevant clinical outcomes (measurement)	Length of follow-up
Germany Ministry of Labour, Health and Social Policies of the State of North-Rhine- Westphalia, Germany; Open access funding enabled and organized by Projekt DEAL	 with a diagnosis of AN (or atypical AN) during their first or second admission for AN with at least 1 carer Exclusion criteria: Anyone with organic brain disease or other severe psychiatric disorders, substance abuse, severe self- injurious behaviour, low intelligence, severe comorbid somatic disorder, inability to speak German, or planned residential treatment Participant characteristics: Sample size: Home treatment cohort (n = 22) Non-home treatment cohort (n = 10) Age, M (SD); Min, Max: Home treatment = 15.06 (1.15); 13.17, 17.03 Non-home treatment = 16.33 (1.13); 14.69, 17.90 Gender, female, n (%): Home treatment = 22 (100%) Non-home treatment = 10 (100%) An subtype diagnosis, n (%): Home treatment restrictive = 22 (100%) Non-home treatment restrictive = 10 (100%) 	which included an individualized treatment plan and multidisciplinary methods of therapy delivery Comparators: Change in clinical outcome at the beginning of treatment to end of treatment; non-home-based treatment participants were used to compare for categorical variables	 (EDE; EDI) AN clinical functioning (MRAOS) Comorbid psychiatric disorder (Mini-International Neuropsychiatric Interview for Children and Adolescents) Depressive symptoms (BDI) Health-related quality of life (Kidscreen-27) Treatment satisfaction (ZUF-8 [CSQ-8]) 	

Authors (year), study design, country, funding source	Relevant participant characteristics	Intervention and comparator(s)	Relevant clinical outcomes (measurement)	Length of follow-up
	 Home treatment atypical AN = 3 (13.6%) 			
	 Non-home treatment atypical AN = 1 (10%) 			
	Duration of illness in weeks, M (SD); Min, Max:			
	 Home treatment = 50.82 (30.75); 3.57, 111.57 			
	 Non-home treatment = 54.93 (30.77); 4.86, 100.14 			
	Psychiatric comorbidities, n (%):			
	 Home treatment: 			
	 At least 1 comorbidity = 18 (81.8%) 			
	 Affective disorder = 17 (77.3%) 			
	 Anxiety disorder = 10 (45.5%) 			
	• OCD = 0			
	 Other = 3 (13.6%) 			
	Non-home treatment:			
	 At least 1 comorbidity = 9 (90%) 			
	 Affective disorder = 10 (100%) 			
	 Anxiety disorder = 6 (60%) 			
	• OCD = 5 (50%)			
	 Other = 1 (10%) 			
Coelho et al., (2019) ¹¹	Inclusion criteria:	Intervention:	 Change in BMI 	Beginning of treatment
Single-arm pre-post cohort study Canada British Columbia Mental Health and Substance Use	Participants with a duration of illness of < 3 years admitted to FBT outpatient ED program with a diagnosis of AN or OSFED	Family-based therapy Comparator: NA (Pre-post intervention analysis)	 Treatment progression 	to end of treatment (over unspecified duration)
Services	Participant characteristics (n = 62):			

Authors (year), study design, country, funding source	Relevant participant characteristics	Intervention and comparator(s)	Relevant clinical outcomes (measurement)	Lenath of follow-up
	Age, M (SD); min, max = 14.6 (2.1); 9, 18 Gender (female), n (%) = 58 (93.5) Diagnosis, n (%): • AN restrictive subtype = 49 (79%) • AN binge/purge subtype = 2 (3.2%) • OSFED restrictive subtype = 10 (16.1%) • OSFED purge subtype = 1 (1.6%) Ethnicity, n (%): • Caucasian = 28 (45.2%) • Asian = 7 (11.2%) • Mixed background = 1 (1.6%) • Not available = 26 (41.9%) Psychiatric comorbidities, n (%): • MDD = 7 (11.3%) • GAD = 8 (12.9%) • SAD = 3 (4.8%) • OCD = 2 (3.2%) • Other anxiety disorder = 14 (22.6%)			
Hurst et al., (2019) ¹²	Inclusion criteria:	Intervention	• ED symptomology	Outcomes were
Single-arm prospective cohort study Australia Funding: none	Participants aged 12 to 17 diagnosed with AN with an illness duration of < 3 years and referred to a specialist outpatient child and adolescent ED service Participant characteristics: Age, M (SD) = 14.9 (1.2)	Family-based therapy in combination with cognitive behavioural therapy focusing on perfectionism Comparator NA (Pre-post intervention analysis)	 (EDI-3) ED psychopathology and behaviour (EDE-Q) Perfectionism (CAPS) Expected body weight 	measured at 4 phases: after FBT commencement [T1]; FBT phase 2 and CBT commencement [T2]; completion of CBT [T3]; and completion of FBT and CBT [T4] (all over unspecified duration)



Authors (year), study design, country, funding source	Relevant participant characteristics	Intervention and comparator(s)	Relevant clinical outcomes (measurement)	Length of follow-up
Rosling et al., (2016) ¹³ Single-arm pre-post cohort study Sweden Crown Princess Lovisa's Fund for Child Health Care; the Gillbergska Foundation; the First of May Flower Annual Campaign; Professor Bror Gadelius Memorial Foundation; the Sven Jerring Foundation; and Uppsala University	Inclusion criteria: Adolescent females aged 10 to 17.9 from Uppsala County who were referred for assessment to the Eating Disorder Unit Relevant participant characteristics: Sample size: AN cohort (n = 31) Age, M (SD) = 15.1 (2.0) DUED (months), M (SD); range = 9.1 (7.3); < 1 to 32	Intervention: Outpatient family-based therapy program Comparator: NA (Pre-post intervention analysis)	 ED symptomology (EDI-C) Depressive symptoms (MADRS-S) AN clinical functioning (MRAOS) 	Baseline to 1-year follow-up
Godard et al., (2012) ¹⁴ RCT France Projet Hospitalier de Recherche Clinique (CRC- PHRC, 1997, AOM97133 AP-HP), French Ministry of Health	Inclusion criteria: Female participants ages 13 to 21 with a diagnosis of AN and < 3 years duration of illness Exclusion criteria: Inability to speak French or understand interview questions, any metabolic pathology interfering with eating or digestion, any psychotic disorder Participant characteristics: Sample size: • Family therapy cohort (n = 30) • TAU cohort (n = 30) Age of illness onset, M (SD): • Family therapy cohort = 14.7 (1.7) • TAU cohort = 15 (1.5) Age at study inclusion, M (SD): • Family therapy cohort = 16.4 (1.7) • TAU cohort = 16.6 (1.7)	Intervention: Systematic family therapy in combination with a multidisciplinary outpatient care program Comparator: TAU multidisciplinary outpatient care program	 Change in BMI Menstrual status Contraceptive use Number of hospitalizations AN clinical functioning (GOAS) ED psychological and behavioural traits (EDI) Social adjustment (SAS) 	Baseline to 6-, 12-, and 18-months follow-up



Authors (year), study design, country, funding source	Relevant participant characteristics	Intervention and comparator(s)	Relevant clinical outcomes (measurement)	Length of follow-up
	Duration of illness in months, M (SD):			
	 Family therapy cohort = 17.1 (8.3) 			
	 TAU cohort = 16.1 (5.2) 			

AN = anorexia nervosa; ARFID = avoidant/restrictive food intake disorder; BDI = Beck Depression Inventory; BED = binge eating disorder; BMI = body mass index; BN = bulimia nervosa; CAPS = Child and Adolescent Perfectionism Scale; CIA = Clinical Impairment Assessment; CORE-10/OM = Clinical Outcomes in Routine Evaluation-10/ Outcome Measure; CSQ-8 = Client Satisfaction Questionnaire; DASS-21 = Depression, Anxiety, and Stress Scale – 21; DUED = duration of untreated eating disorder; DUSC = duration until specialist contact; ED = eating disorder; EDE = Eating Disorder Examination; EDE-Q = Eating Disorder Examination Questionnaire; EDI = Eating Disorder Inventory; FACES III = Family Adaptability and Cohesion Scale; FBT = family-based treatment; FREED = First Episode Rapid Early Intervention for Eating Disorder; GAD = generalized anxiety disorder; GOAS = Global Outcome Assessment Schedule; LEE = Levels of Expressed Emotion Scale; M = mean; MADRS-S = Montgomery-Asberg Depression Rating Scale-Self Report; MDD = major depressive disorder; MRAOS = Morgan and Russel Average Outcome Score; NA = not applicable; NHS = National Health Service; NIHR = National Institute for Health Research; OCD = obsessive compulsive disorder; OSFED = other specified feeding or eating disorder; PSYCHLOPS = Psychological Outcome Profiles; RCT = randomized controlled trial; SAD = social anxiety disorder; SAS = Social Adjustment Scale; SCL-90-R = Symptom Check List 90-Revised; SD = standard deviation; WSAS = Work and Social Adjustment Scale.

^aFREED is a service aimed to offer participants with ED early assessment and treatment according to pre-specified wait time targets in tandem with treatment considered to be evidence-based [e.g., CBT, Maudsley AN treatment for adults] with tailoring to participant developmental needs and early stage illness.

^bTAU cohort refers to a retrospective audit of electronic participant records used to assess outcomes from the same study sites from 2 years before the FREED service model was implemented.

°Missing data cases were not included in the percentage calculations.

^dNo baseline participant characteristics were presented for TAU cohort.

Summary of Outcome Measurements

Table 3: Summary of Outcome Measurements

Outcome Domain	Outcome Measurement Tool	Description	Minimally Important Difference
ED symptomology	EDE-Q	The EDE-Q is a 28-item self-report questionnaire designed to assess the range, frequency, and severity of behaviours associated with an ED. ¹⁵ Users are assessed on 4 subscales including restraint, eating concern, shape concern, and weight concern. Each subscale is scored as an average between 0 and 6, with higher scores indicating greater frequency or severity of eating disorder psychopathology over the previous 28 days. ¹⁶ An overall global score ranging from 0 and 6 is assigned by summing the four subscale scores and diving by the number of subscales (i.e., 4), with a higher score indicating more problematic eating outcomes. ¹⁵	EDE-Q global score's clinically significant cut-off in populations including people living with an ED diagnosis = ≥ 2.17 to 3.19 ^{17 to 19,a}



Outcome Domain	Outcome Measurement Tool	Description	Minimally Important Difference
	ED-15	The ED-15 is a 15-item self-report questionnaire to assess eating attitudes and behaviours. ²⁰ The questionnaire scores the frequency of 10 attitudes over the preceding week using a 7-point Likert scale, ranging from 0 (not at all) to 6 (all the time). ²¹ An overall attitudinal score between 0 and 6 is assigned using the mean of the scores on all 10 attitudinal items. ²¹ The questionnaire also includes 5 questions related to the frequency of problematic eating behaviours in the previous week (i.e., binge eating, vomiting episodes, laxative misuse, eating restraint, and excessive exercise), scored as the number of times or the number of days each behaviour occurred. ²¹	No information
	EDI	The EDI is a standardized, 64-item, self-report questionnaire that assesses a broad range of behavioural and attitudinal characteristics associated with EDs. ²² The EDI consists of 8 subscales measuring: drive for thinness, bulimia, body dissatisfaction, ineffectiveness, perfectionism, interpersonal distrust, interoceptive awareness, and maturity fears. ²³ Each item is rated as occurring always, usually, often, sometimes, rarely, or never. Responses to each item are assigned a score between from 0 to 3. ²³ Subscale scores are calculated by summing scores from each item within the subscale, with higher scores indicating increased frequency of cognitive and behavioural characteristics associated with EDs. ²³	No information
	DUED	DUED refers to the length of time (often reported in months or years) between when an individual developed an ED and when they first initiated evidence-based treatment. ⁵	No information
	DUSC	DUSC refers to the length of time (often reported in months or years) between when an individual developed an ED and the date of specialist clinical assessment. ⁵	No information
BMI and menstrual outcomes	BMI score	BMI is a value derived from the mass and height of an individual. It is calculated by dividing a person's weight in kilograms by their height in metres. The Canadian	Not applicable



Outcome Domain	Outcome Measurement Tool	Description	Minimally Important Difference
		Guidelines for Body Weight Classification in Adults ²⁴ assigns four categories of BMI ranges in adults:	
		• underweight (BMI less than 18.5 kg/m ²)	
		 normal weight (BMI from 18.5 kg/m² to 24.9 kg/m²) 	
		 overweight (BMI from 25 kg/m² to 29.9 kg/m²) 	
		 obese (BMI 30 kg/m² and over) 	
		In children, it is not feasible to categorize individuals into categories based on absolute BMI thresholds because most anthropometric measures vary by age and sex. ²⁵	
	EBW	%EBW is a measure of an individual's BMI relative to a typical person of their age. It is calculated by dividing an individual's BMI by the median age-adjusted BMI and multiplying by 100. ¹⁰ A value greater than 100% indicates the individual has a BMI higher than the median age-adjusted BMI, while values lower than 100% indicate the individual has a BMI lower than the median age-adjusted BMI. ¹⁰	No information identified
	MROAS	The MROAS is a guided interview that identifies clinical features central to the syndrome of anorexia nervosa. ²⁶ It consists of 5 domains: including: food intake and nutritional status, menstrual state, mental state, psychosexual adjustment, and socioeconomic status. ²⁶ A score from 0 to 12 is determined for each domain depending on the individual's responses, with higher scores indicating better clinical status. ^{10,26} A final average score is determined by calculating the average score across the 5 domains. ²⁶	No information identified
	MROC	 MROC is used to classify an individual's outcome following treatment as good, intermediate, or poor. In Godart et al. (2022),⁹ categories were defined as: good (BMI equal to or higher than the 10th percentile and regular menstruation) intermediate (BMI greater than the 10th percentile but amenorrhea (i.e., the absence of menstruation for at least the past three months) 	No information identified



Outcome Domain	Outcome Measurement Tool	Description	Minimally Important Difference
		 poor (BMI less than 10th percentile or presence of bulimic symptoms) 	
Psychological impact	CORE-10/OM	The CORE-OM is a 34-item self-report instrument that includes 4 subscales designed to assess subjective well-being, symptoms, function, and risk. ²⁷ The frequency that each item has occurred over the previous week is scored on a 5-point Likert scale between 0 (not at all) and 4 (most or all the time). A total raw score can be calculated by summing the scores for each item (ranging from 0 to 136), and scores for each subscale can be calculated by adding the value assigned to each item within the domain. ²⁸ The average response for an individual (ranging from 0 to 4) can be calculated by dividing the total raw score by the number of items (i.e., 34). ²⁸ Higher scores indicate higher psychological distress. ²⁷ The CORE-10 is shortened version of the CORE-OM that includes 10 items. ²⁹ The frequency that each item has occurred over the previous week is scored on a 5-point Likert scale between 0 (not at all) and 4 (most or all the time). ²⁹ Total scores range between 0 and 40 and are calculated using the sum of the scores for each item. ²⁹ Higher CORE-10 scores indicate higher level of general psychological distress, with a total score of 11 or above being clinically significant. ³⁰ Average scores (ranging from 0 to 4) can also be calculated by diving the total score by the number of items (i.e., 10). ²⁹	CORE-OM clinically significant cut-off points for men (M) and women (W) for unspecified clinical and non-clinical populations: ^b • Mean item score = 1.19 (M); 1.29 (W) ³¹
	CIA	The CIA is a 16-item self-report questionnaire to assess severity of psychosocial impairment due to ED. ^{32,33} It includes 3 subscales: personal impairment (6 items), social impairment (5 items), and cognitive impairment (5 items). Each item is rated on a 4-point Likert scale (0 = not at all; 3 = a lot) that reflects how often the item has occurred in the past month. ³² A global score (ranging from 0 to 48) is calculated by adding the values for each item, with higher values indicating higher levels of psychosocial impairment. ³² A global score of 16 represents clinically significant impairment. ³³	No information identified



	Outcome	Description	
Outcome Domain			Na information identified
	DASS-21	The DASS-21 is a 21-item self-report scale designed to measure the negative emotional state of depression, anxiety, and stress. ³⁴ It is the short form of the DASS-42, and consists of 3 subscales (depression, anxiety, stress) that each contain 7 items. ³⁴ Items are scored on a scale of 0 (did not apply at all) to 3 (applied very much or most of the time) to indicate how much the statement applied to the individual over the past week. ³⁴ Scores for each subscale ranging from 0 to 21 are calculated by summing the values for each relevant item, with higher scores indicating higher levels of depression, anxiety, or stress. ³⁴ Subscale scores are multiplied by 2 to yield values that can be compared with the original DASS-42. ³⁵ Total scores are calculated by summing the 3 subscale scores. ³⁴	No information identified
	LEE	The LEE scale is a 60-item self- administered questionnaire that measures the perception of expressed emotion in a person's influential relationships. ^{27,36} It consists of 4 subscales that assess attitude toward illness, emotional response, intrusiveness, and tolerance and expectations. ^{2,36} Each subscale includes 15 items that are rated in true-false format, and the scale generates scores for each of the 4 subscales and an overall expressed emotion score. ³⁷ Higher scores indicate greater perceived expressed emotion. ^{7,36}	No information identified
	PSYCHLOPS	PSYCHLOPS is a psychometric instrument that can be used as an outcome measure to assess participants perspectives on their psychological distress. ³⁸ It consists of 3 domains: problems, functioning, and wellbeing. ³⁸ Four questions included in the PSYCHLOPS are rated using a using a 6-point Likert scale, ranging from 0 to 5. ³⁹ Total scores are generated by summing the value assigned to each of these questions and range from 0 to 20. ³⁹ Higher scores indicate higher psychological difficulty. ³⁹	No information identified
	SCL-90-R	The SCL-90-R is a 90-item self-report questionnaire for measuring a range of psychological and psychiatric symptoms. ^{40,41} It assesses 9 primary	SCL-90-R clinically significant cut-off points for population with generalized



Outcome Domain	Outcome Measurement Tool	Description	Minimally Important Difference
		symptom dimensions containing 6 to 13 items each, including somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. ⁴² Each item is scored on a 5-point scale (0 = not at all; 4 = extremely), with higher numbers indicting more intense symptoms within the past week. ⁴² A score is determined for each of the 9 symptom scales by summing values from relevant items. ⁴⁰ These 9 primary dimensions are then summed to provide 3 global indices of psychological distress: Global Severity Index, the Positive Symptom Distress Index, and the Positive Symptoms Total. ⁴¹ A total score is assigned using the sum of all items. ^{40,42}	psychological conditions: ^c • Global severity index = 0.60 ^d ; 1.20 ^{43,e}
	BDI-II	The BDI-II is a 21-item self-report questionnaire that assesses depressive symptoms among the emotional, cognitive, motivational, and physiological domains of depression. ⁴⁴ Published in 1996, it is a revised version of the BDI that that corresponds with the depression diagnostic criteria defined in DSM-IV. ⁴⁵ Each item is answered on a 4-point Likert scale between 0 and 3, with higher scores indicating increasing symptom severity. ⁴⁵ Total scores range between 0 and 63 and are calculated using the sum of the scores for each item. ⁴⁵ Total scores can be used to classify the severity of depressive symptoms as minimal (0 to 13), mild (14 to 19), moderate (20 to 28), and severe (29 or greater). ⁴⁶	No information identified
	CAPS	The CAPS is a 22-item self-report questionnaire used to assess perfectionism in young people. ¹² It includes 2 subscales that measure self-oriented perfectionism (12 items) and socially prescribed perfectionism (10 items). Each item is rated on a 5-point scale (0 = false—not at all true of me; 4 = very true of me). ⁴⁷ Ratings are used to assigned scores for each item, which are then summed to generate subscale scores. ⁴⁷ Self-oriented perfectionism and socially prescribed perfectionism subscale scores range between 12 and 60 and	No information identified



Outcome Domain	Outcome Measurement Tool	Description	Minimally Important Difference
		10 and 50, respectively. ⁴⁷ Higher scores indicate higher levels of perfectionism. ⁴⁷	
Work and social adjustment	WSAS	The WSAS is a 5-item self-report scale of social functional impairment attributable to a specific problem or disorder (e.g., an individual's ED). ⁴⁸ Each item is evaluated on a scale ranging from 0 (no impairment at all) to 8 (very severe impairment). ⁴⁸ A total score ranging from 0 to 40 is calculated by summing the value assigned to each item, with higher scoring indicating higher impairment. ⁴⁸	No information identified
Health care utilization	SAS	The SAS is a 54-item self-report scale used to assess social adjustment and role performance in the past 2 weeks across 6 domains: work and school, social and leisure, extended family, primary relationship, parental, and family unit. ⁴⁹ Each item is assigned a score between 1 and 5, with higher scores indicating greater impairment in functioning. ⁵⁰ An overall score can be calculated by summing the scores of all the items and dividing by the number of items. ⁵⁰	No information identified
Health care utilization	ZUF-8	The ZUF-8 is an 8-item self-report questionnaire used to measure treatment satisfaction. ¹⁰ Each item is rated on a 4-point Likert scale, which are coded from 1 to 4. ¹⁰ Scores from each of the 8 items are summed to generate a total score that ranges from 8 to 32, with higher values indicating decreased treatment satisfaction. ¹⁰	No information identified
Global functioning outcomes	Kidscreen-27	The Kidscreen-27 is a 27-item self-report questionnaire that assesses health-related quality of life across five domains: physical well-being (5 items), psychological wellbeing (7 items), parent relations and autonomy (7 items), social support and peers (4 items), and school environment (4 items). ⁵¹ It can be applied to both children and caregivers. ⁵¹ Each item is rated using 5 possible multiple-choice responses (e.g., not at all, slightly, moderately, very, extremely), which are assigned a score between 1 and 5. ⁵² For each domain, a scoring algorithm is used to calculate T-scores with a mean of 50 and a standard deviation of 10. ⁵¹ A total score ranging	No information identified

Outcome Domain	Outcome Measurement Tool	Description	Minimally Important Difference
		from 27 to 135 is calculated by summing the values from each item, with higher scores indicating higher health-related quality of life. ⁵²	
	GOAS	The GOAS evaluates the central clinical features of anorexia nervosa.	No information identified

AN = anorexia nervosa; BDI-II = Beck Depression Inventory-II; BMI = body mass index; CAPS = Child and Adolescent Perfectionism Scale; CIA = Clinical Impairment Assessment; CORE-10/OM = Clinical Outcomes in Routine Evaluation-10/Outcome Measure; DASS-21; Depression, Anxiety and Stress Scale-21; DSM-IV = Diagnostic and Statistical Manual of Mental Disorders, fourth edition; DUED = duration of untreated eating disorder; DUSC = duration of eating disorder onset to specialist contact; EBW = expected body weight; ED = eating disorder; ED-15 = eating disorder-15 questionnaire; EDE-Q = Eating Disorder Examination Questionnaire; EDI = eating disorder inventory; GOAS = Global Outcome Assessment Schedule; LEE = Level of Expressed Emotion; MROAS = Morgan-Russel Outcome Assessment Schedule; MROC = Morgan and Russel Outcome Categories; PSYCHLOPS = Psychological Outcome Profile; SAS = Social Adjustment Scale; SCL-90-R = Symptom Check List 90-Revised; WSAS = Work and Social Adjustment Scale.

^aThree studies provided clinically significant cut-off points for EDE-Q scores.¹⁷⁻¹⁹ These three studies were deemed relevant to provide adequate interpretation for clinically meaningful change because of the overlap between the populations (i.e., included people living with an ED diagnosis) and application of the EDE-Q score measurements. Overall, the EDE-Q score's clinically significant cut-off points from each study were 2.17,¹⁸ 2.40,¹⁹ and ≥ 3.19 ,¹⁷ giving a clinical significant cut-off range of ≥ 2.17 to 3.19. This can be interpreted as any EDE-Q score that is within or above this range can be considered a clinically meaningful change in behaviours associated with ED. It should be noted that the population within these studies included adults, which limits the applicability of these cut-off points to adolescent and young adult populations.

^bOne study provided a clinically significant cut-off point of 1.19 for men and 1.29 for women for CORE-OM mean scores.³¹ The cut-off points from this study were not deemed to be appropriate to inform our understanding of clinically meaningful change because of the heterogeneity between the use of CORE-OM measurements from the reference study³¹ and the context of the studies included in this review. In addition, findings from the included studies were not reported by gender thus providing challenges to accurately determine which clinical significance cut-off point would be relevant to the outcome presented in this review.

^cOne study provided clinically significant cut-off points of 0.60 and 1.20 for SCL-90-R in functional to moderately symptomatic and moderately to severely symptomatic populations, respectively, with generalized psychological conditions.⁴³ The cut-off points from this study were not deemed to be appropriate to inform our understanding of clinically meaningful change because of the heterogeneity between the populations in which these outcomes are applied (i.e., generalized psychological conditions in the reference study vs. EDs in the included studies of this review).

^dFunctional to moderately symptomatic population.

^eModerately to severely symptomatic population.



Critical Appraisal of Included Clinical Studies

Table 4: Risk of Bias in the Included Nonrandomized Studies Using ROBINS-I

Study citation	Bias due to confounding	Bias in selection of participants into study	Bias in classification of intervention	Bias due to deviations from intended intervention	Bias due to missing data	Bias in measurement of outcomes	Bias in selection of reported results	Overall bias
			Early	Intervention Program	Studies			
Richards et al., (2023) ¹	Serious ROB [?] 1.1 (PY) Confounding factors may impact the effect of intervention 1.2 (N) All participants received the same intervention so analysis was not based on follow- up time 1.4 (N) Authors did not report using appropriate analysis method to control for confounding 1.6 (N) Authors did not control for any post- intervention variables that could have been affected by intervention	Moderate ROB [+] 2.1 (N) Selection of participants was not based on participant characteristics observed after the start of the intervention 2.4 (Y) Intervention and follow-up was applied uniformly across participant groups (e.g., baseline data, 6-month and 12-month follow- up data)	Serious ROB [?] 3.1 (N) There was sufficient ambiguity in FREED-4-All participant and FREED-Up participant groups. It was unclear if there was any cross over between groups 3.2 (N) It is unclear when information used to define intervention groups was recorded 3.3 (N) Knowledge of intervention status would not have affected potential outcomes	Low ROB [+] 4.3 (NI) No co- interventions were included in the analysis 4.4 (PY) Implementation of intervention was likely successful for included participants 4.5 (PY) It is unlikely that participants would not adhere to FREED intervention regimen 4.6 (NA)	Serious ROB [+] 5.1 (N) There was a significant amount of missing data from both FREED- 4-All and FREED-Up participants for follow-up measurements 5.2 (PN) It was not indicated that participants were excluded due to missing data 5.3 (PN) It was not indicated that participants were excluded due to missing data on other variables needed for the analysis 5.4 (PN) One intervention group had a much higher proportion of missing data at follow-up	Moderate ROB [?] 6.1 (PN) Outcome measures would not be influenced by knowledge of intervention group 6.2 (PY) Assessors were likely aware of which intervention group was being assessed 6.3 (Y) Similar methods of outcome assessments were used across intervention group 6.4 (PN) Errors in outcome measurements are likely not attributable to intervention received	Moderate ROB [?] 7.1 (PN) Outcomes assessed were not likely measured multiple times 7.2 (PY) For certain outcomes multiple analyses were done over different time point to assess change 7.3 (N) Different subgroups were not analyzed	Serious ROB [+]

Study citation	Bias due to confounding	Bias in selection of participants into study	Bias in classification of intervention	Bias due to deviations from intended intervention	Bias due to missing data	Bias in measurement of outcomes	Bias in selection of reported results	Overall bias
					5.5 (PN) It is not clear that the results are robust with the presence of missing data			
Austin et al., (2022) ²	Serious ROB [?] 1.13 (PY) Confounding factors (e.g., age, gender, location, illness type, treatment) may impact the effect of intervention 1.2 (N) All participants received the same intervention so analysis was not based on follow- up time 1.4. (N) Authors did not report using appropriate analysis method to control for confounding 1.6 (N) Authors did not control for any post- intervention	Moderate ROB [+] 2.1 (N) Selection of participants was not based on participant characteristics observed after the start of the intervention 2.4 (Y) Intervention and follow-up was applied uniformly across participant groups (e.g., baseline data, 6-month and 12-month follow- up data)	Low ROB [?] 3.1 (Y) Intervention groups were presented with clear detail (FREED cohort vs TAU cohort) 3.2 (Y) Information used to classify intervention groups were not likely to be confused due to one group being a historical cohort comparator 3.3 (N) Knowledge of the outcomes would not impact classification of intervention group	Low ROB [+] 4.3 (NI) No co- interventions were included in the analysis 4.4 (PY) Implementation of intervention was likely successful for included participants 4.5 (PY) It is unlikely that participants would not adhere to FREED intervention regimen 4.6 (NA)	Moderate ROB [?] 5.1 (Y) Outcome data was presented for nearly all participants from baseline to follow- up 5.2 (PN) It was not indicated that participants were excluded due to missing data 5.3 (PN) It was not indicated that participants were excluded due to missing data on other variables needed for the analysis	Moderate ROB [?] 6.1 (PN) Outcome measures would not be influenced by knowledge of intervention group 6.2 (PY) Assessors were likely aware of which intervention group was being assessed 6.3 (Y) Similar methods of outcome assessments were used across intervention group 6.4 (PN) Errors in outcome measurements are likely not attributable to intervention received	Moderate ROB [?] 7.1 (PN) Outcomes assessed were not likely measured multiple times 7.2 (PY) For certain outcomes multiple analyses were done over different time point to assess change 7.3 (PN) Different diagnostic subgroups were analyzed but it is unclear if this impacted reported effect estimates	Serious ROB [?]



Study citation	Bias due to confounding	Bias in selection of participants into study	Bias in classification of intervention	Bias due to deviations from intended intervention	Bias due to missing data	Bias in measurement of outcomes	Bias in selection of reported results	Overall bias
	variables that could have been affected by intervention							
Radunz et al., (2021) ³	Serious ROB [?] 1.1 (PY) Confounding factors (e.g., age, gender, location, illness type, treatment) may impact the effect of intervention 1.2 (N) All participants received the same intervention so analysis was not based on follow- up time 1.4 (N) Authors did not report using appropriate analysis method to control for confounding 1.6 (N) Authors did not control for any post- intervention variables that	Serious ROB [+] 2.2 (N) Selection of participants was not based on participant characteristics observed after the start of the intervention 6.3 (PY) It is likely that the start of intervention and data extracted at follow-up were at similar time points for participants	Serious ROB [+] 3.1 (Y) Only 1 intervention group was included in the analysis 3.2 (Y) Information used to define intervention group was likely recorded at the start of the intervention 3.3 (PN) Since only 1 intervention group was analyzed, it is unlikely that knowledge of outcomes would impact intervention group	Moderate ROB [+] 4.3 (NI) Co- interventions were not included in this analysis 4.4 (PY) It is likely that intervention implementation was successful for most participants 4.5 (Y) Participants likely adhered to intervention regimen	Serious ROB [+] 5.1 (N) There was a significant amount of missing data for follow-up outcome measurements 5.2 (PN) It was not indicated that participants were excluded due to missing data 5.3 (PN) It was not indicated that participants were excluded due to missing data on other variables needed for the analysis 5.4 (NA) Only 1 intervention group was analyzed 5.5 (PN) There is no indication that appropriate	Serious ROB [+] 6.1 (PN) Only 1 intervention group was included in the analysis which likely did not impact outcome measures 6.2 (Y) Assessors were aware of which intervention group was being assessed 6.3 (NI) Only 1 intervention group was included in the analysis 6.4 (PN) Errors in outcome measurements are likely not attributable to intervention received	Serious ROB [+] 7.1 (PY) Multiple outcome measurements were used for certain outcome domains 7.2 (PY) For certain outcomes multiple analyses were done over different time point to assess change #7.3 (N) No subgroup analysis was complete	Serious ROB [+]

Study citation	Bias due to confounding	Bias in selection of participants into study	Bias in classification of intervention	Bias due to deviations from intended intervention	Bias due to missing data	Bias in measurement of outcomes	Bias in selection of reported results	Overall bias
	could have been affected by intervention				methods were used to account for missing data			
Richards et al., (2021) ⁴	Serious ROB [?] 1.1 (PY) Confounding factors (e.g., age, gender, location, illness type, treatment) may impact the effect of intervention 1.2 (N) All participants received the same intervention so analysis was not based on follow- up time 1.4 (N) Authors did not report using appropriate analysis method to control for confounding 1.6 (N) Authors did not control for any post- intervention variables that could have been	Moderate ROB [?] 2.1 (N) Selection of participants was not based on participant characteristics observed after the start of the intervention 2.4 (PY) It is likely that intervention and follow-up analysis was done uniformly for most participants	Moderate ROB [?] 3.1 (Y) Intervention groups were presented with clear detail (FREED cohort vs TAU cohort) 3.2 (Y) Information used to classify intervention groups were not likely to be confused due to one group being a historical cohort comparator 3.3 (N) Knowledge of the outcomes would not impact classification of intervention group	Low ROB [?] 4.3 (NI) No co- interventions were included in the analysis 4.4 (PY) Implementation of intervention was likely successful for included participants 4.5 (PY) It is unlikely that participants would not adhere to FREED intervention regimen 4.6 (NA)	Moderate ROB [+] 5.1 (Y) Outcome data was available for nearly all participants 5.2 (PN) It was not indicated that participants were excluded due to missing data 5.3 (PN) It was not indicated that participants were excluded due to missing data on other variables needed for the analysis	Moderate ROB [?] 6.1 (PN) Outcome measures would not be influenced by knowledge of intervention group 6.2 (PY) Assessors were likely aware of which intervention group was being assessed 6.3 (Y) Similar methods of outcome assessments were used across intervention group 6.4 (PN) Errors in outcome measurements are likely not attributable to intervention received	Moderate ROB [?] 7.1 (PN) Outcomes assessed were not likely measured multiple times 7.2 (PY) For certain outcomes multiple analyses were done over different time point to assess change 7.3 (PN) Different diagnostic subgroups were analyzed but it is unclear if this impacted reported effect estimates	Serious ROB [?]

Study citation	Bias due to confounding	Bias in selection of participants into study	Bias in classification of intervention	Bias due to deviations from intended intervention	Bias due to missing data	Bias in measurement of outcomes	Bias in selection of reported results	Overall bias
	affected by intervention							
Flynn et al., (2020)⁵	Serious ROB [?] 1.1 (PY) Confounding factors (e.g., age, gender, location, illness type, treatment) may impact the effect of intervention 1.2 (N) All participants received the same intervention so analysis was not based on follow- up time 1.5 (N) Authors did attempt to minimize confounding factors, but no appropriate analysis method to control for confounding was used 1.6 (N) Authors did not control for any post-	Moderate ROB [?] 2.1 (N) Selection of participants was not based on participant characteristics observed after the start of the intervention 2.4 (PY) It is likely that intervention and follow-up analysis was done uniformly for most participants	Low [?] 3.1 (Y) Intervention groups were presented with clear detail (FREED cohort vs TAU cohort) 3.2 (Y) Information used to classify intervention groups were not likely to be confused due to one group being a historical cohort comparator 3.3 (N) Knowledge of the outcomes would not impact classification of intervention group	Low ROB [+] 4.1 (NI) No co- interventions were included in the analysis 4.2 (PY) Implementation of intervention was likely successful for included participants 4.3 (PY) It is unlikely that participants would not adhere to FREED intervention regimen	Serious ROB [+] 5.1 (NI) No information was reported related to loss to follow-up or missing outcome data 5.2 (NI) No information was provided relating to how potential missing data was handled 5.3 (NI) No information was provided relating to how potential missing data was handled for variables needed for the analysis	Serious ROB [+] 6.1 (PN) Outcome measures would not be influenced by knowledge of intervention group 6.2 (PY) Assessors were likely aware of which intervention group was being assessed 6.3 (N) Different methods of outcome assessment were used between the FREED cohort and TAU cohort 6.4 (PN) Errors in outcome measurements are likely not attributable to intervention received	Moderate ROB [?] 7.1 (PN) Outcomes assessed were not likely measured multiple times 7.2 (PY) For certain outcomes multiple analyses were done over different time point to assess change 7.3 (N) No subgroup analysis was complete	Serious ROB [?]



Study citation	Bias due to confounding	Bias in selection of participants into study	Bias in classification of intervention	Bias due to deviations from intended intervention	Bias due to missing data	Bias in measurement of outcomes	Bias in selection of reported results	Overall bias
	intervention variables that could have been affected by intervention							
Fukutomi et al., (2019) ⁶	Serious ROB [?] 1.1 (PY) Confounding factors (e.g., age, gender, location, illness type, treatment) may impact the effect of intervention 1.2 (N) All participants received the same intervention so analysis was not based on follow- up time 1.4 (N) Authors did not report using appropriate analysis method to control for confounding 1.6 (N) Authors did not control for any post- intervention	Moderate ROB [?] 2.1 (N) Selection of participants was not based on participant characteristics observed after the start of the intervention 2.4 (PY) It is likely that intervention and follow-up analysis was done uniformly for most participants	Moderate [?] 3.1 (Y) Intervention groups were presented with clear detail (FREED cohort vs TAU cohort) 3.2 (PY) Analysis was done on historical cohort data so misclassification of intervention status is unlikely 3.3 (N) Knowledge of the outcomes would not impact classification of intervention group	Low ROB [?] 4.3 (NI) No co- interventions were included in the analysis 4.4 (PY) Implementation of intervention was likely successful for included participants 4.5 (PY) It is unlikely that participants would not adhere to FREED intervention regimen	Moderate ROB [?] 5.1 (PY) Due to use of retrospective cohort data, it is unlikely that significant amount of data was missing 5.2 (N) Analysis was complete to include participants with potential missing data on intervention status 5.3 (N) Analysis was complete to include participants with potential missing data on variables needed for analysis	Low ROB [?] 6.1 (PN) Outcome measures would not be influenced by knowledge of intervention group 6.2 (PY) Assessors were likely aware of which intervention group was being assessed 6.3 (Y) Similar methods of outcome assessments were used across intervention group 6.4 (PN) Errors in outcome measurements are likely not attributable to intervention received	Moderate ROB [?] 7.1 (PN) Outcomes assessed were not likely measured multiple times 7.2 (PY) For certain outcomes multiple analyses were done over different time point to assess change 7.3 (N) No subgroup analysis was complete	Serious ROB [?]



Study citation	Bias due to confounding	Bias in selection of participants into study	Bias in classification of intervention	Bias due to deviations from intended intervention	Bias due to missing data	Bias in measurement of outcomes	Bias in selection of reported results	Overall bias
	variables that could have been affected by intervention							
McClelland et al., (2018) ⁷	Serious ROB [?] 1.1 (PY) Confounding factors (e.g., age, gender, location, illness type, treatment) may impact the effect of intervention 1.2 (N) All participants received the same intervention so analysis was not based on follow- up time 1.4 (N) Authors did not report using appropriate analysis method to control for confounding 1.6 (N) Authors did not control for any post- intervention variables that	Moderate ROB [?] 2.1 (N) Selection of participants was not based on participant characteristics observed after the start of the intervention 2.4 (PY) It is likely that intervention and follow-up analysis was done uniformly for most participants	Low ROB [?] 3.1 (Y) Intervention groups were presented with clear detail (FREED cohort vs TAU cohort) 3.2 (Y) Information used to classify intervention groups were not likely to be confused due to one group being a historical cohort comparator 3.3 (N) Knowledge of the outcomes would not impact classification of intervention group	Low ROB [?] 4.3 (NI) No co- interventions were included in the analysis 4.4 (PY) Implementation of intervention was likely successful for included participants 4.5 (PY) It is unlikely that participants would not adhere to FREED intervention regimen	Serious ROB [+] 5.1 (N) There was a significant amount of missing data for follow-up outcome measurement for FREED cohort and audit cohort 5.2 (N) Analysis was complete to include participants with potential missing data on intervention status 5.3 (N) Analysis was complete to include participants with potential missing data on variables needed for analysis 5.4 Proportions	Serious ROB [+] 6.1 (PN) Outcome measures would not be influenced by knowledge of intervention group 6.2 (PY) Assessors were likely aware of which intervention group was being assessed 6.3 (N) Different methods of outcome assessment were used between the FREED cohort and audit cohort 6.4 (PN) Errors in outcome measurements are likely not attributable to intervention received	Moderate ROB [?] 7.1 (PN) Outcomes assessed were not likely measured multiple times 7.2 (PY) For certain outcomes multiple analyses were done over different time point to assess change 7.3 (N) No subgroup analysis was complete	Serious ROB [?]

Study citation	Bias due to confounding	Bias in selection of participants into study	Bias in classification of intervention	Bias due to deviations from intended intervention	Bias due to missing data	Bias in measurement of outcomes	Bias in selection of reported results	Overall bias
	could have been affected by intervention				of missing data to follow-up were larger for TAU cohort compared to FREED cohort 5.5 (PY) Appropriate statistical analysis using mixed models was used allowing for missing data to be included and may allow for a robust analysis			
Brown et al., (2016) ⁸	Serious ROB [?] 1.1 (PY) Confounding factors (e.g., age, gender, location, illness type, treatment) may impact the effect of intervention 1.2 (N) All participants received the same intervention so analysis was not based on follow- up time	Moderate ROB [?] 2.1 (N) Selection of participants was not based on participant characteristics observed after the start of the intervention 2.4 (PY) It is likely that intervention and follow-up analysis was done uniformly	Low ROB [?] 3.1 (Y) Intervention groups were presented with clear detail (FREED cohort vs TAU cohort) 3.2 (Y) Information used to classify intervention groups were not likely to be confused due to one group being a	Low ROB [?] 4.3 (NI) No co- interventions were included in the analysis 4.4 (PY) Implementation of intervention was likely successful for included participants 4.5 (PY) It is unlikely that participants would not adhere to	Serious ROB [?] 5.1 (NI) No information was reported related to loss to follow-up or missing outcome data 5.2 (NI) No information was provided relating to how potential missing data was handled 5.3 (NI) No information was	Serious ROB [+] 6.1 (PN) Outcome measures would not be influenced by knowledge of intervention group 6.2 (PY) Assessors were likely aware of which intervention group was being assessed 6.3 (N) Different methods of outcome	Moderate ROB [?] 7.1 (PN) Outcomes assessed were not likely measured multiple times 7.2 (PY) For certain outcomes multiple analyses were done over different time point to assess change	Serious ROB [?]


Study citation	Bias due to confounding	Bias in selection of participants into study	Bias in classification of intervention	Bias due to deviations from intended intervention	Bias due to missing data	Bias in measurement of outcomes	Bias in selection of reported results	Overall bias
	 1.4 (N) Authors did not report using appropriate analysis method to control for confounding 1.6 (N) Authors did not control for any post- intervention variables that could have been affected by intervention 	for most participants	historical cohort comparator 3.3 (N) Knowledge of the outcomes would not impact classification of intervention group	FREED intervention regimen	provided relating to how potential missing data was handled for variables needed for the analysis	assessment were used between the FREED cohort and audit cohort 6.4 (PN) Errors in outcome measurements are likely not attributable to intervention received	7.3 (N) No subgroup analysis was complete	
			Studies of Interver	ntion Programs at the E	Early Phase of Illness			
Herpertz- Dahlmann et al., (2021) ¹⁰	Serious ROB [+] 1.1 (PY) Confounding factors (e.g., age, gender, location, illness type, treatment) may impact the effect of intervention 1.2 (N) All participants received the same intervention so analysis was not based on follow- up time	Moderate ROB [+] 2.1 (N) Selection of participants was not based on participant characteristics observed after the start of the intervention 2.4 (PY) The intervention and follow-up was likely applied similarly for all participants	Serious ROB [+] 3.1 (Y) Only 1 intervention group was included in the analysis 3.2 (Y) Information used to define intervention group was likely recorded at the start of the intervention 3.3 (PN) Since only 1 intervention group	Moderate ROB [+] 4.1 (PN) It is unlikely that there are significant deviations from intended intervention that would impact outcome assessment	Moderate ROB [+] 5.1.3 (Y) Outcome data and follow-up data was available for nearly all participants 5.2 (NI) No information was provided relating to how potential missing data was handled 5.3 (NI) No information was provided relating	Serious ROB [+] 6.1 (PN) Only 1 intervention group was included in the analysis which likely did not impact outcome measures 6.2 (Y) Assessors were aware of which intervention group was being assessed 6.3 (NI) Only 1 intervention group was included in	Moderate ROB [+] 7.1 (PN) Outcomes assessed were not likely measured multiple times 7.2 (PY) For certain outcomes multiple analyses were done over different time point to assess change 7.3 (N) No	Serious ROB [+]

Early Intervention Programs for Adolescents and Young Adults with Eating Disorders – Supporting Information



Study citation	Bias due to confounding	Bias in selection of participants into study	Bias in classification of intervention	Bias due to deviations from intended intervention	Bias due to missing data	Bias in measurement of outcomes	Bias in selection of reported results	Overall bias
	1.4 (N) Authors did not report using appropriate analysis method to control for confounding 1.5 (N) Authors did not control for any post- intervention variables that could have been affected by intervention	included in the study	was analyzed, it is unlikely that knowledge of outcomes would impact intervention group		to how potential missing data was handled for variables needed for the analysis	the analysis 6.4 (PN) Errors in outcome measurements are likely not attributable to intervention received	subgroup analysis was complete	
Coelho et al., (2019) ¹¹	Serious ROB [+] 1.1 (PY) Confounding factors (e.g., age, gender, location, illness type, treatment) may impact the effect of intervention 1.2 (N) All participants received the same intervention so analysis was not based on follow- up time 1.4 (N) Authors	Moderate ROB [+] 2.1 (N) Selection of participants was not based on participant characteristics observed after the start of the intervention 2.4 (PY) The intervention and follow-up was likely applied similarly for all participants included in the study	Serious ROB [+] 3.1 (Y) Only 1 intervention group was included in the analysis 3.2 (Y) Information used to define intervention group was likely recorded at the start of the intervention 3.3 (PN) Since only 1 intervention group was analyzed,	Moderate ROB [+] 4.1 (PN) It is unlikely that there are significant deviations from intended intervention that would impact outcome assessment	Moderate ROB [+] 5.1 (Y) Outcome data and follow-up data was available for nearly all participants 5.2 (NI) No information was provided relating to how potential missing data was handled 5.3 (NI) No information was provided relating to how potential	Serious ROB [+] 6.1 (PN) Only 1 intervention group was included in the analysis which likely did not impact outcome measures 6.2 (Y) Assessors were aware of which intervention group was being assessed 6.3 (NI) Only 1 intervention group was included in the analysis	Moderate ROB [+] 7.1 (PN) Outcomes assessed were not likely measured multiple times 7.2 (PY) For certain outcomes multiple analyses were at program admission and discharge 7.3 (N) No subgroup	Serious ROB [+]

Early Intervention Programs for Adolescents and Young Adults with Eating Disorders – Supporting Information

Study citation	Bias due to confounding	Bias in selection of participants into study	Bias in classification of intervention	Bias due to deviations from intended intervention	Bias due to missing data	Bias in measurement of outcomes	Bias in selection of reported results	Overall bias
	did not report using appropriate analysis method to control for confounding 1.5 (N) Authors did not control for any post- intervention variables that could have been affected by intervention		it is unlikely that knowledge of outcomes would impact intervention group		missing data was handled for variables needed for the analysis	6.4 (PN) Errors in outcome measurements are likely not attributable to intervention received	analysis was complete	
Hurst et al., (2019) ¹²	Serious ROB [+] 1.1 (PY) Confounding factors (e.g., age, gender, location, illness type, treatment) may impact the effect of intervention 1.2 (N) All participants received the same intervention so analysis was not based on follow- up time 1.4 (N) Authors did not report	Moderate ROB [+] 2.1 (N) Selection of participants was not based on participant characteristics observed after the start of the intervention 2.4 (PY) The intervention and follow-up was likely applied similarly for all participants included in the study	Serious ROB [+] 3.1 (Y) Only 1 intervention group was included in the analysis 3.2 (Y) Information used to define intervention group was likely recorded at the start of the intervention 3.3 (PN) Since only 1 intervention group was analyzed, it is unlikely	Moderate ROB [+] 4.1 (PN) It is unlikely that there are significant deviations from intended intervention that would impact outcome assessment	Moderate ROB [+] 5.1 (Y) Outcome data and follow-up data was available for nearly all participants 5.2 (NI) No information was provided relating to how potential missing data was handled 5.3 (NI) No information was provided relating to how potential missing data	Serious ROB [+] 6.1 (PN) Only 1 intervention group was included in the analysis which likely did not impact outcome measures 6.2 (Y) Assessors were aware of which intervention group was being assessed 6.3 (NI) Only 1 intervention group was included in the analysis 6.4 (PN) Errors	Serious ROB [+] 7.1 (PY) For each outcome domain, multiple outcome measurements were included in the analysis 7.2 (PY) Multiple analysis of intervention- outcome results were included in the analysis 7.3 (N) No subgroup analysis was complete	Serious ROB [+]

Study citation	Bias due to confounding	Bias in selection of participants into study	Bias in classification of intervention	Bias due to deviations from intended intervention	Bias due to missing data	Bias in measurement of outcomes	Bias in selection of reported results	Overall bias
	using appropriate analysis method to control for confounding 1.5 (N) Authors did not control for any post- intervention variables that could have been affected by intervention		that knowledge of outcomes would impact intervention group		was handled for variables needed for the analysis	in outcome measurements are likely not attributable to intervention received		
Rosling et al., (2016) ¹³	Serious ROB [+] 1.1 (PY) Confounding factors (e.g., age, gender, location, illness type, treatment) may impact the effect of intervention 1.2 (N) All participants received the same intervention so analysis was not based on follow- up time 1.4 (N) Authors did not report using appropriate	Moderate ROB [+] 2.2 (N) Selection of participants was not based on participant characteristics observed after the start of the intervention 2.4 (PY) The intervention and follow-up was likely applied similarly for all participants included in the study	Serious ROB [+] 3.1 (Y) Only 1 intervention group was included in the analysis 3.2 (Y) Information used to define intervention group was likely recorded at the start of the intervention 3.3 (PN) Since only 1 intervention group was analyzed, it is unlikely that knowledge	Serious ROB [+] 4.3 (NI) No co- interventions were included in the analysis 4.4 (PY) Implementation of intervention was likely successful for included participants 4.5 (PY) Only 1 intervention was used and it is likely that participants adhered to intervention given	Serious ROB [+] 5.1 (N) There was a significant amount of participants that were lost to follow-up and had missing data 5.2 (NI) No information was provided relating to how potential missing data was handled 5.3 (NI) No information was provided relating to how potential missing data	Serious ROB [+] 6.1 (PN) Only 1 intervention group was included in the analysis which likely did not impact outcome measures 6.2 (Y) Assessors were aware of which intervention group was being assessed 6.3 (NI) Only 1 intervention group was included in the analysis 6.4 (PN) Errors in outcome	Serious ROB [+] 7.1 (PN) Outcomes assessed were not likely measured multiple times 7.2 (PY) For certain outcomes multiple analyses were done over different time point to assess change 7.3 (N) No subgroup analysis was complete	Serious ROB [+]



Study citation	Bias due to confounding	Bias in selection of participants into study	Bias in classification of intervention	Bias due to deviations from intended intervention	Bias due to missing data	Bias in measurement of outcomes	Bias in selection of reported results	Overall bias
	analysis method to control for confounding 1.5 (N) Authors did not control for any post- intervention variables that could have been affected by intervention		of outcomes would impact intervention group		was handled for variables needed for the analysis 5.4 (NA) Only 1 intervention group was included in the analysis 5.5 (PY) Analysis of missing data was included and provides evidence that results of analysis were robust	measurements are likely not attributable to intervention received		

FREED = First Episode Rapid Early Intervention for Eating Disorder; ROB = risk of bias; ROBINS-I = Risk of Bias In Nonrandomized Studies of Interventions; vs. = versus.

Note: the predicted direction of bias arising from each domain and overall risk of bias is indicated in square brackets. [?] = direction of bias is unpredictable; [+] direction of bias may favour the intervention group; [-] direction of bias may favour away from the intervention group



Table 5: Risk of Bias in the Included Randomized Controlled Trials Assessed Using ROB 2

Study citation	Bias due to randomization process	Bias due to deviations from intended intervention	Bias due to missing outcome data	Bias in measurement of the outcome	Bias in selection of reported results	Overall risk of bias
		Studies of Inte	rvention Programs at the I	Early Phase of Illness		
Godart et al., (2022); ⁹ Godart et al., (2012) ¹⁴	Some concerns [?] 1.1 (Y) Randomization was done in block methods using an SPSS randomization program 1.2 (Y) Allocation of intervention group was sealed in an envelope so participants were unaware of intervention status 1.3 (N) There was minimal baseline differences between intervention groups post-randomization which suggests there was no issue with the randomization process	Some concerns [+] 2.1 (PY) Based on the type of intervention, it would be unlikely that the participants were unaware of the intervention they would be receiving (i.e., family therapy vs no family therapy) 2.2 (Y) Blinding program administrators would not be possible for the intervention included 2.3 (N) No changes or deviations to assigned intervention group was reported 2.6 (PY) The trial first used intention-to-treat analysis then per- protocol analysis for to estimate the effect of assignment to treatment	Some concerns [?] 2.6 (Y) Nearly all data was available for participants that were randomized at baseline and last available follow-up, any missing data was similar across intervention groups	Some concern [?] 4.1 (PN) Methods of outcome measures were verified and appropriate 4.2 (PN) Methods of outcome measurements were applied uniformly for each intervention group at comparable time points 4.3 (N) Assessors of outcomes measures were blinded to participant intervention status	High ROB [?] 5.1 (Y) A pre-specified analysis plan was used before outcome data was available for analysis 5.2 (PY) Outcome measurements were assessed at multiple time points using results from scales, which may impact selection of reported results 5.3 (PN) Measurements of results were likely only analyzed in one way but at multiple time points	High ROB [?]

ROB 2 = Risk of Bias Tool for Randomized Trials; SPSS = Statistical Package for the Social Sciences.

Note: the predicted direction of bias arising from each domain and overall risk of bias is indicated in square brackets. [?] = direction of bias is unpredictable; [+] direction of bias may favour the intervention group.



Detailed Findings for Early Intervention Program Studies

Table 6: Summary of Detailed Findings for Eating Disorder Symptomology Outcomes

Outcome	Study citation	Detailed findings
EDE-Q score	Richards et al., (2023) ¹	Results of all participants from the FREED-Up cohort (n analyzed = 278 at baseline [T1]; 182 at 6 months [T2]; 175 at 12 months [T3])
		 EDE-Q scores, M (SD) at T1 vs T2; MD = 4.08 (1.21) vs 2.85 (1.57); 1.23 (P < 0.001)
		 EDE-Q scores, M (SD) at T1 vs T3; MD = 4.08 (1.21) vs 2.31(1.55); 1.77 (P < 0.001)
		 % (n) above EDE-Q clinical cut-off (> 2.8) at T1, T2, and T3 = 84% (233); 49% (89); 35% (61)
		Results of all participants from the FREED-4-All cohort (n analyzed = 793 at baseline [T1]; 135 at post-treatment [T2])
		 EDE-Q scores, M (SD) at T1 vs T2; MD = 4.06 (1.29) vs 2.04 (1.39); 2.02 (P < 0.001)
-		 % (n) above EDE-Q clinical cut-off (> 2.8) at T1 and T2 = 84% (633); 29% (39)
	Austin et al., (2022) ²	Results of all participants from the FREED cohort (n analyzed = 278 at baseline [T1]; 216 at 3 months [T2]; 182 at 6 months [T3]; 175 at 12 months [T4])
		 EDE-Q score MD (95% Cl) at T1 vs T2; SE (P value) = -0.92 (-1.07 to -0.78); 0.074 (P < 0.001)
		 EDE-Q score MD (95% Cl) at T2 vs T3; SE (P value) = -0.34 (-0.50 to -0.18); 0.080 (P < 0.001)
		 EDE-Q score MD (95% Cl) at T3 vs T4; SE (P value) = -0.49 (-0.66 to -0.32); 0.11 (P < 0.001)
		 EDE-Q score MD (95% Cl) at T1 vs T4; SE (P value) = -1.75 (-1.97 to -1.54); 0.11 (P < 0.001)
	Radunz et al., (2021) ³	Results of mean EDE-Q scores from baseline (n analyzed = 96) and end of treatment (n analyzed = 30)
		 Baseline EDE-Q score, M (SD) = 4.25 (1.12)
		 End of treatment EDE-Q score, M (SD) = 1.87 (1.12)
		 Between group difference, d (95% CI) = 2.05 (1.43 to 2.68)
		• P < 0.001
	McClelland et al., (2018) ⁷	Results of mean EDE-Q score from all participants from the FREED cohort (n analyzed = 53 at baseline [T1]; 37 at 3 months [T2]; 32 at 6 months [T3]; 25 at 12 months [T4])
		• T1 score, M (SD) = 4.0 (1.3)
		• T2 score, M (SD) = 3.2 (1.4)
		• T3 score, M (SD) = 2.5 (1.4)
		• T4 score, M (SD) = 2.2 (1.6)
		Mean change in EDE-Q score from T1 (n analyzed = 53) to T2 (n analyzed = 37) of all participants from the FREED cohort



Outcome	Study citation	Detailed findings
		• M (95% Cl) = -0.82 (-1.21 to -0.43)
		• P = 0.001
		Mean change in EDE-Q score from T1 (n analyzed = 53) to T3 (n analyzed = 32) of all participants from the FREED cohort
		• M (95% Cl) = -1.55 (-2.06 to -1.05)
		• P = 0.001
		Mean change in EDE-Q score from T1 (n analyzed = 53) to T4 (n analyzed = 25) of all participants from the FREED cohort
		• M (95% Cl) = -2.08 (-2.76 to -1.41)
		• P = 0.001
		Mean change in EDE-Q score from T3 (n analyzed = 32) to T4 (n analyzed = 25) of all participants from the FREED cohort
		• M (95% Cl) = -0.53 (-1.02 to -0.03)
		• P = 0.03
ED cognition	Radunz et al., (2021) ³	Change in linear trend for ED-15 outcome (ED cognition) across days since treatment commencement (0 to 70 days)
		 Change (SE) = −0.022 (0.0022)
		• P < 0.001
		Change in quadratic trend for ED-15 outcome (ED cognition) across days since treatment commencement (0 to 70 days)
		 Change (SE) = 0.00006 (0.00001)
		• P < 0.001
Binge episodes	Richards et al., (2023) ¹	Results of all participants from the FREED-Up cohort (n analyzed = 278 at baseline [T1]; 182 at 6 months [T2]; 175 at 12 months [T3])
		 Binge episodes per month, M (SD) at T1 vs T2; MD = 6.41 (8.39) vs 3.70 (8.17); 2.71 (P < 0.001)
		 Binge episodes per month, M (SD) at T1 vs T3; MD = 6.41 (8.39) vs 2.39 (4.60); 4.02 (P < 0.001)
		Results of all participants from the FREED-4-All cohort (n analyzed = 820 at baseline [T1]; 151 at post-treatment [T2])
		 Binge episodes per month, M (SD) at T1 vs T2; MD = 4.83 (10.17) vs 2.19 (4.84); 2.64 (P < 0.001)
	Austin et al., (2022) ²	Results of participants diagnosed with BN, BED, or OSFED from the FREED cohort (n analyzed = 125 at baseline [T1]; 76 at 12 months [T4]) ^a
		 Binge episodes MD (95% CI) at T1 vs T2; SE (P value) = −5.53 (−7.28 to −3.79); 0.88 (P < 0.001)
		 Binge episodes MD (95% CI) at T2 vs T3; SE (P value) = -0.19 (-1.72 to 2.10); 0.97 (P = 0.84)
		 Binge episodes MD (95% CI) at T3 vs T4; SE (P value) = -2.56 (-4.58 to 0.55); 1.02 (P = 0.13)
		 Binge episodes MD (95% CI) at T1 vs T4; SE (P value) = -8.29 (-10.09 to -6.48); 0.92 (P < 0.001)



Outcome	Study citation	Detailed findings
	Radunz et al., (2021) ³	Change in linear trend for ED-15 outcome (binge eating) across days since treatment commencement (0 to 70 days)
		 Change (SE) = −0.02 (0.0041)
		• P < 0.001
		Change in quadratic trend for ED-15 outcome (binge eating) across days since treatment commencement (0 to 70 days)
		• Change (SE) = 0.00009 (0.00003)
		• P < 0.001
Purging episodes	Richards et al., (2023) ⁴	Results of all participants from the FREED-Up cohort (n analyzed = 278 at baseline [T1]; 182 at 6 months [T2]; 175 at 12 months [T3])
		 Vomit episodes per month, M (SD) at T1 vs T2; MD = 6.97 (11.76) vs 3.27 (9.73); 3.70 (P < 0.001)
		 Vomit episodes per month, M (SD) at T1 vs T3; MD = 6.97 (11.76) vs 2.39 (4.60); 4.79 (P < 0.001)
		Results of all participants from the FREED-4-All cohort (n analyzed = 821 at baseline [T1]; 150 at post-treatment [T2])
_		 Vomit episodes per month, M (SD) at T1 vs T2; MD = 5.84 (15.07) vs 1.43 (3.98); 4.41 (P < 0.001)
	Austin et al. $(2022)^2$	Results of participants diagnosed with BN, BED, or OSFED from the FREED cohort (n analyzed = 98 at baseline [T1]; 56 at 12 months [T4]) ^a
		 Vomiting episodes MD (95% CI) at T1 vs T2; SE (P value) = −6.51 (−8.42 to −4.61); 0.97 (P < 0.001)
		 Vomiting episodes MD (95% CI) at T2 vs T3; SE (P value) = -0.76 (-2.84 to 1.31); 1.05 (P = 0.47)
		 Vomiting episodes MD (95% CI) at T3 vs T4; SE (P value) = -2.86 (-5.14 to -0.58); 1.16 (P = 0.014)
		 Vomiting episodes MD (95% Cl) at T1 vs T4; SE (P value) = −10.13 (−13.23 to −7.03); 1.58 (P < 0.001)
	Radunz et al., (2021) ³	Change in linear trend for ED-15 outcome (vomiting) across days since treatment commencement (0 to 70 days)
		 Change (SE) = -0.008 (0.0029)
		• P = 0.008
		Change in quadratic trend for ED-15 outcome (vomiting) across days since treatment commencement (0 to 70 days)
		• Change (SE) = 0.00005 (0.00002)
		• P = 0.02
Laxative use	Richards et al., (2023) ¹	Results of all participants from the FREED-Up cohort (n analyzed = 278 at baseline [T1]; 182 at 6 months [T2]; 175 at 12 months [T3])
		 Laxative episodes per month, M (SD) at T1 vs T2; MD = 2.03 (6.52) vs 1.13 (4.22); 0.90 (P < 0.05)
		 Laxative episodes per month, M (SD) at T1 vs T3; MD = 2.03 (6.52) vs 0.55 (2.93); 1.48 (P < 0.001)
		Results of all participants from the FREED-4-All cohort (n analyzed = 823 at baseline [T1]; 153 at post-treatment [T2])



Outcome	Study citation	Detailed findings
		 Laxative episodes per month, M (SD) at T1 vs T2; MD = 1.30 (5.71) vs 0.46 (2.83); 0.84 (not SS)
	Austin et al., (2022) ²	Results of participants diagnosed with BN, BED, or OSFED from the FREED cohort (n analyzed = 39 at baseline [T1]; 23 at 12 months [T4]) ^a
		 Laxative use MD (95% CI) at T1 vs T2; SE (P value) = -5.66 (-8.50 to -2.82); 1.42 (P < 0.001)
		 Laxative use MD (95% Cl) at T2 vs T3; SE (P value) = -1.05 (-4.16 to 2.06); 1.56 (P = 0.5)
		 Laxative use MD (95% Cl) at T3 vs T4; SE (P value) = -2.55 (-5.80 to -0.70); 1.00 (P = 0.12)
		 Laxative use MD (95% Cl) at T1 vs T4; SE (P value) = −9.26 (−12.40 to −6.12); 1.56 (P < 0.001)
	Radunz et al., (2021) ³	Change in linear trend for ED-15 outcome (laxative use) across days since treatment commencement (0 to 70 days)
		• Change (SE) = 0.004 (0.02)
		• P = 0.86
		Change in quadratic trend for ED-15 outcome (laxative use) across days since treatment commencement (0 to 70 days)
		 Change (SE) = 0.000001 (0.00001)
		• P = 0.92
Excessive exercise	Austin et al., (2022) ²	Results of participants diagnosed with BN, BED, or OSFED from the FREED cohort (n analyzed = 112 at baseline [T1]; 62 at 12 months [T4]) ^a
		 Excessive exercise MD (95% CI) at T1 vs T2; SE (P value) = -6.10 (-7.56 to -4.64); 0.74 (P < 0.001)
		 Excessive exercise MD (95% Cl) at T2 vs T3; SE (P value) = -2.22 (-3.82 to -0.62); 0.81 (P = 0.007)
		 Excessive exercise MD (95% Cl) at T3 vs T4; SE (P value) = -0.63 (-2.38 to 1.13); 0.89 (P = 0.48)
		 Excessive exercise MD (95% CI) at T1 vs T4; SE (P value) = -8.95 (-11.04 to -6.86); 1.06 (P < 0.001)
	Radunz et al., (2021) ³	Change in linear trend for ED-15 outcome (driven exercise) across days since treatment commencement (0 to 70 days)
		 Change (SE) = -0.013 (0.0042)
		• P < 0.001
		Change in quadratic trend for ED-15 outcome (driven exercise) across days since treatment commencement (0 to 70 days)
		 Change (SE) = 0.00003 (0.00005)
		• P = 0.03
Restrictive dieting	Radunz et al., (2021) ³	Change in linear trend for ED-15 outcome (restrictive dieting) across days since treatment commencement (0 to 70 days)
		 Change (SE) = −0.024 (0.0072)
		• P < 0.001
		Change in quadratic trend for ED-15 outcome (restrictive dieting) across days since treatment commencement (0 to 70 days)



Outcome	Study citation	Detailed findings
		• Change (SE) = 0.00007 (0.00005)
		• P = 0.01
DUSC	Flynn et al., (2020)⁵	Results of DUSC (months) for participants diagnosed with AN, BN, BED, OSFED from the total FREED cohort (n analyzed = 278)
		• AN, M (SD) = 16.50 (10.58)
		• BN, M (SD) = 19.35 (10.34)
		• BED, M (SD) = 17.67 (8.33)
		• OSFED, M (SD) = 15.09 (9.85)
		 Total, M (SD) = 16.82 (10.31)
		Results of DUSC (months) for participants diagnosed with AN, BN, BED, OSFED under optimal conditions from FREED cohort (n analyzed = 157)
		• AN, M (SD) = 13.29 (8.85)
		• BN, M (SD) = 18.94 (10.69)
		• BED, M (SD) = 17.67 (8.33)
		• OSFED, M (SD) = 12.95 (8.35)
		 Total, M (SD) = 15.11 (9.58)
		Results of DUSC (months) for participants diagnosed with AN, BN, BED, OSFED from TAU cohort (n analyzed = 224)
		• AN, M (SD) = 15.62 (10.67)
		• BN, M (SD) = 19.81 (9.30)
		• BED, M (SD) = 16.75 (10.87)
		• OSFED, M (SD) = 16.38 (11.20)
		 Total, M (SD) = 16.47 (10.41)
		Between group comparison of total DUSC (months) from total FREED cohort (n = 278) vs TAU cohort (n = 224)
		• P = 0.71
		● 95% CI = -1.49 to 2.13
		Between group comparison of total DUSC (months) from FREED cohort under optimal conditions (n = 157) vs TAU cohort (n = 224)
		• P = 0.200
		● 95% CI = -3.45 to 0.72
	Brown et al., (2016) ⁸	Mean DUSC (months) for all FREED cohort (n analyzed = 51), FREED cohort with minimal gatekeeping (n analyzed = 14), FREED cohort with complex gatekeeping (n analyzed = 37), and TAU cohort (n analyzed = 89)
		 All FREED cohort, M (SD) = 15.6/ (10.04) EDEED as here with relianced metalways in 14 (SD) = 10.45 (0.14)
		• FREED cohort with minimal gatekeeping, M (SD) = 12.45 (9.14)
		• FREED cohort with complex gatekeeping, M (SD) = 16.89 (10.21)
		• TAU CONORT, MI (SD) = 16.16 (10.63)
DUED	Flynn et al., (2020)⁵	Results of DUED (months) for participants diagnosed with AN, BN, BED, OSFED from the total FREED cohort (n analyzed = 278)
		• AN, M (SD) = 17.50 (10.62)
		• BN, M (SD) = 20.26 (10.45)



Outcome	Study citation	Detailed findings
		• BED, M (SD) = 18.67 (8.33)
		• OSFED, M (SD) = 16.30 (9.84)
		• Total, M (SD) = 17.85 (10.38)
		Results of DUED (months) for participants diagnosed with AN, BN, BED, OSFED under optimal conditions from FREED cohort (n analyzed = 157)
		• AN, M (SD) = 14.02 (9.08)
		• BN, M (SD) = 19.72 (10.76)
		• BED, M (SD) = 18.67 (8.33)
		• OSFED, M (SD) = 14.05 (8.37)
		• Total, M (SD) = 15.95 (9.74)
		Results of DUED (months) for participants diagnosed with AN, BN, BED, OSFED from TAU cohort (n analyzed = 224)
		• AN, M (SD) = 18.57 (11.27)
		• BN, M (SD) = 23.05 (9.35)
		• BED, M (SD) = 18.00 (11.40)
		• OSFED, M (SD) = 19.90 (12.64)
		 Total, M (SD) = 19.98 (11.13)
		Between group comparison of total DUED (months) from total FREED cohort (n = 278) vs TAU cohort (n = 224)
		• P < 0.05
		• 95% CI = -4.23 to -0.31
		Between group comparison of total DUED (months) from FREED cohort under optimal conditions (n = 157) vs TAU cohort (n = 224)
		• P < 0.001
		• 95% Cl = -6.04 to -1.68•
	Brown et al., (2016) ⁸	Mean DUED (months) for all FREED cohort (n analyzed = 51), FREED cohort with minimal gatekeeping (n analyzed = 14), FREED cohort with complex gatekeeping (n analyzed = 37), and TAU cohort (n analyzed = 65)
		• All FREED cohort, M (SD) = 16.39 (10.08)
		 FREED cohort with minimal gatekeeping, M (SD) = 13.04 (9.29)
		• FREED cohort with complex gatekeeping, M (SD) = 17.66 (10.20)
		• TAU cohort, M (SD) = 19.09 (11.67)
		• P = 0.07 for FREED cohort with minimal gatekeeping vs TAU cohort

BED = binge eating disorder; BN = bulimia nervosa; CI = confidence interval; DUED = duration of untreated eating disorder; DUSC = duration of time until specialist service contact; ED = eating disorder; EDE-Q = Eating Disorder Examination Questionnaire; FREED = First Episode Rapid Early Intervention for Eating Disorder; M = mean; MD = mean difference; OSFED = other specified feeding or eating disorder; SD = standard deviation; SE = standard error; SS = statistically significant; t = t test; vs = versus. ^aNumber of participants analyzed at 3 months (T2) and 6 months (T3) was not reported.

Table 7: Summary of Detailed Findings for Body Mass Index Outcomes

Outcome	Study citations	Detailed findings
BMI score	Richards et al., (2023) ¹	Results of all AN participants from the FREED-Up cohort (n analyzed = 96 at baseline [T1]; 76 at 6 months [T2]; 66 at 12 months [T3]) BMI score, M (SD) at T1 vs T2; MD = 16.42 (1.19) vs 17.67 (1.77); -1.25



Outcome	Study citations	Detailed findings
		(P < 0.001)
		 BMI score, M (SD) at T1 vs T3; MD = 16.42 (1.19) vs 18.43 (2.23); -2.01 (P < 0.001)
		 % (n) of participants with AN above BMI threshold (> 18.5 kg/m²) at T1, T2, and T3 = 0% (0); 33% (25); 52% (34)
		Results of all AN participants from the FREED-4-All cohort (n analyzed = 429 at baseline [T1]; 88 at post-treatment [T2])
		 BMI score, M (SD) at T1 vs T2; MD = 17.41 (2.24) vs 19.08 (2.55); -1.67 (P < 0.001)
		 % (n) of participants with AN above BMI threshold (> 18.5 kg/m²) at T1 and T2 = 22% (93); 59% (52)
	Austin et al., (2022) ²	Estimated mean BMI score (kg/m²) of AN participants for FREED cohort (n = 117) vs TAU cohort (n = 116)
		 M (95% Cl) = 18.65 (18.27 to 19.03) vs 17.33 (16.75 to 17.90)
		• MD (95% Cl) = 1.32 (0.63 to 2.02)
		Estimated mean BMI points gained for AN participants at baseline (T1) to 12 months (T4) for FREED cohort vs TAU cohort ^a
		 M (95% Cl) = 2.09 (1.66 to 2.53) vs 1.22 (0.59 to 1.86)
		Proportion of participants who were weight recovered (BMI > 18.5 kg/m^2) at each time point, n/N (%)
		 FREED cohort vs TAU cohort at baseline = 5/117 (4.35%) vs 5/78 (6.4%)
		 FREED cohort vs TAU cohort at 3 months = 18/105 (17.1%) vs 8/59 (13.6%)
		 FREED cohort vs TAU cohort at 6 months; P value = 31/92 (33.7%) vs 8/55 (14.5%); P = 0.011
		 FREED cohort vs TAU cohort at 12 months; P value = 42/79 (53.2%) vs 5/28 (17.9%); P < 0.001
	Radunz et al., (2021) ³	Results of mean BMI score (kg/m ²) from baseline (n analyzed = 70) and end of treatment (n analyzed = 43)
		 Baseline BMI score, M (SD) = 22.14 (0.85)
		 End of treatment BMI score, M (SD) = 23.11 (0.85)
		 Between group difference, d (95% Cl) = −0.21 (−0.72 to 0.30)
		• P < 0.001
	Fukutomi et al., (2019) ⁶	Results of mean BMI (kg/m²) at final time point (24-month follow-up) for FREED-AN cohort (n analyzed = 11) vs TAU-AN cohort (n analyzed = 8)
		• FREED-AN, M (95% CI) = 19.2 (18.21 to 20.16)
		• TAU-AN, M (95% CI) = 18.0 (16.90 to 19.15)
		• MD (95% Cl) = 1.1 (-0.44 to 2.66)
		Mean BMI increase (kg/m ²) from assessment to final time point (24-month follow-up) for FREED-AN cohort (n analyzed = 11) vs TAU-AN cohort (n analyzed = 8)
		• FREED-AN, M (95% CI) = 2.7 (1.57 to 3.85)
		• TAU-AN, M (95% CI) = 1.9 (0.75 to 3.14)
		• P = 0.06



Outcome	Study citations	Detailed findings
		Proportion of participants who were weight recovered (BMI > 18.5 kg/m ²) between 12- and 24-month follow-up for FREED-AN cohort and TAU-AN cohort
		• FREED-AN, n/N (%) = 12/17 (71%)
		• TAU-AN, n/N (%) = 2/9 (22%)
		• P = 0.02
		Proportion of participants who were weight recovered (BMI > 18.5 kg/m ²) across all time points for FREED-AN cohort and TAU-AN cohort
		• FREED-AN, n/N (%) = 13/22 (59%)
		• TAU-AN, n/N (%) = 5/28 (21%)
		• P = 0.003
	McClelland et al., (2018) ⁷	Results of mean BMI score (kg/m ²) from all participants from the FREED cohort (n analyzed = 50 at baseline [T1]; 45 at 3 months [T2]; 35 at 6 months [T3]; 30 at 12 months [T4])
		• T1 score, M (SD) = 19.8 (3.7)
		• T2 score, M (SD) = 19.7 (3.3)
		• T3 score, M (SD) = 19.9 (2.9)
		• T4 score, M (SD) = 20.7 (3.2)
		Mean change in BMI score (kg/m²) from T1 (n analyzed = 50) to T2 (n analyzed = 45) of all participants from the FREED cohort
		• M (95% Cl) = 0.16 (-0.40 to 0.71)
		• P = 1.00
		Mean change in BMI score (kg/m²) from T1 (n analyzed = 50) to T3 (n analyzed = 35) of all participants from the FREED cohort
		• M (95% Cl) = 0.69 (-0.02 to 1.41)
		• P = 0.064
		Mean change in BMI score (kg/m²) from T1 (n analyzed = 50) to T4 (n analyzed = 30) of all participants from the FREED cohort
		• M (95% Cl) = 1.20 (0.29 to 2.12)
		• P = 0.004
		Mean change in BMI score (kg/m²) from T3 (n analyzed = 35) to T4 (n analyzed = 30) of all participants from the FREED cohort
		• M (95% Cl) = 0.51 (-0.16 to 1.18)
		• P = 0.229

AN = anorexia nervosa; BMI = body mass index; CI = confidence interval; FREED = First Episode Rapid Early Intervention for Eating Disorder; M = mean; MD = mean difference; SD = standard deviation; TAU = treatment as usual; vs = versus. No measure of effect was report between FREED cohort and TAU cohort.

Table 8: Summary of Detailed Findings for Psychological Impact Outcomes

Outcome	Study citation	Detailed findings
Psychological distress	Richards et al., (2023) ¹	Results of all participants from the FREED-Up cohort (n analyzed = 277 at baseline [T1]; 182 at 6 months [T2]; 175 at 12 months [T3]) • CORE-10/OM score, M (SD) at T1 vs T2; MD = 1.97 (0.75) vs 1.45 (0.74);



Outcome	Study citation	Detailed findings
		0.52 (P < 0.001)
		 CORE-10/OM score, M (SD) at T1 vs T3; MD = 1.97 (0.75) vs 1.39 (0.85); 0.58 (P < 0.001)
		Results of all participants from the FREED-4-All cohort (n analyzed = 577 at baseline [T1]; 76 at post-treatment [T2])
		 CORE-10/OM score, M (SD) at T1 vs T2; MD = 1.93 (0.72) vs 1.42 (0.83); 0.51 (P < 0.001)
	Austin et al., (2022) ²	Results of all participants from the FREED cohort (n analyzed = 277 at baseline [T1]; 216 at 3 months [T2]; 182 at 6 months [T3]; 175 at 12 months [T4])
		 CORE-10/OM score MD (95% CI) at T1 vs T2; SE (P value) = -2.59 (-3.42 to -1.77); 0.42 (P < 0.001)
		 CORE-10/OM score MD (95% CI) at T2 vs T3; SE (P value) = -2.49 (-3.39 to -1.58); 0.46 (P < 0.001)
		 CORE-10/OM score MD (95% CI) at T3 vs T4; SE (P value) = -0.94 (-1.8 to 0.02); 0.49 (P = 0.054)
		 CORE-10/OM score MD (95% CI) at T1 vs T4; SE (P value) = -6.02 (-7.08 to -4.95); 0.54 (P < 0.001)
	McClelland et al., (2018) ⁷	Results of mean CORE-10 score from all participants from the FREED cohort (n analyzed = 53 at baseline [T1]; 37 at 3 months [T2]; 32 at 6 months [T3]; 25 at 12 months [T4])
		• T1 score, M (SD) = 19.8 (8.2)
		• T2 score, M (SD) = 16.1 (7.0)
		• T3 score, M (SD) = 14.2 (7.8)
		• T4 score, M (SD) = 15.4 (8.3)
		Mean change in CORE-10 score from T1 (n analyzed = 53) to T2 (n analyzed = 37) of all participants from the FREED cohort
		• M (95% CI) = -3.61 (-6.81 to -0.42)
		• P = 0.019
		Mean change in CORE-10 score from T1 (n analyzed = 53) to T3 (n analyzed = 32) of all participants from the FREED cohort
		• M (95% CI) = -5.57 (-9.00 to -2.13)
		• P = 0.001
		Mean change in CORE-10 score from T1 (n analyzed = 53) to T4 (n analyzed = 25) of all participants from the FREED cohort
		● M (95% CI) = −5.43 (−9.33 to −1.54)
		• P = 0.002
		Mean change in CORE-10 score from T3 (n analyzed = 32) to T4 (n analyzed = 25) of all participants from the FREED cohort
		• M (95% Cl) = -0.13 (-3.83 to -4.09)
		• P = 1.00
Psychological impairment due to ED	Austin et al., (2022) ²	Results of all participants from the FREED cohort (n analyzed = 276 at baseline [T1]; 214 at 3 months [T2]; 180 at 6 months [T3]; 173 at 12 months [T4])



Outcome	Study citation	Detailed findings
		 CIA score MD (95% CI) at T1 vs T2; SE (P value) = -5.35 (-6.59 to -3.90); 0.67 (P < 0.001)
		 CIA score MD (95% CI) at T2 vs T3; SE (P value) = -3.85 (-5.31 to -2.38); 0.75 (P < 0.001)
		 CIA score MD (95% CI) at T3 vs T4; SE (P value) = -4.26 (-5.82 to -2.69); 0.80 (P < 0.001)
		 CIA score MD (95% CI) at T1 vs T4; SE (P value) = -13.35 (-15.31 to -11.38); 1.00 (P < 0.001)
	Radunz et al., (2021) ³	Results of mean CIA score from baseline (n analyzed = 96) and end of treatment (n analyzed = 30)
		• Baseline CIA score, M (SD) = 35.23 (1.66)
		 End of treatment CIA score, M (SD) = 14.53 (1.66)
		 Between group difference, d (95% CI) = 2.32 (1.66 to 2.97)
		• P < 0.001
	McClelland et al., (2018) ⁷	Results of mean CIA score from all participants from the FREED cohort (n analyzed = 52 at baseline [T1]; 32 at 3 months [T2]; 33 at 6 months [T3]; 26 at 12 months [T4])
		• T1 score, M (SD) = 1.8 (0.62)
		• T2 score, M (SD) = 1.67 (0.66)
		• T3 score, M (SD) = 1.20 (0.69)
		• T4 score, M (SD) = 1.0 (0.71)
		Mean change in CIA score from T1 (n analyzed = 52) to T2 (n analyzed = 32) of all participants from the FREED cohort
		• M (95% Cl) = -0.18 (-0.47 to 0.10)
		• P = 0.102
		Mean change in CIA score from T1 (n analyzed = 52) to T3 (n analyzed = 33) of all participants from the FREED cohort
		• M (95% CI) = -0.66 (-0.95 to -0.36)
		• P = 0.001
		Mean change in CIA score from T1 (n analyzed = 52) to T4 (n analyzed = 26) of all participants from the FREED cohort
		• M (95% Cl) = -0.98 (-1.33 to -0.63)
		• P = 0.001
		Mean change in CIA score from T3 (n analyzed = 33) to T4 (n analyzed = 26) of all participants from the FREED cohort
		• M (95% Cl) = -0.33 (-0.66 to 0.00)
		• P = 0.053
Depression, anxiety, and stress	Austin et al., (2022) ²	Results of all participants from the FREED cohort (n analyzed = 278 at baseline [T1]; 216 at 3 months [T2]; 182 at 6 months [T3]; 175 at 12 months [T4])
		 DASS-21 score MD (95% CI) at T1 vs T2; SE (P value) = -5.06 (-6.54 to -3.57); 0.76 (P < 0.001)
		 DASS-21 score MD (95% CI) at T2 vs T3; SE (P value) = -3.54 (-5.16 to -1.92); 0.83 (P < 0.001)



Outcome	Study citation	Detailed findings
		 DASS-21 score MD (95% Cl) at T3 vs T4; SE (P value) = -3.10 (-4.82 to -1.38); 0.88 (P < 0.001)
		 DASS-21 score MD (95% CI) at T1 vs T4; SE (P value) = -11.70 (-13.77 to -9.62); 1.05 (P < 0.001)
	Radunz et al., (2021) ³	Results of mean depression score measured by DASS-21 from baseline (n analyzed = 96) and end of treatment (n analyzed = 30)
		 Baseline depression score, M (SD) = 1.94 (0.13)
		 End of treatment depression score, M (SD) = 0.82 (0.13)
		 Between group difference, d (95% CI) = 1.60 (1.02 to 2.18) P < 0.001
		Results of mean anxiety score measured by DASS-21 from baseline (n analyzed = 96) and end of treatment (n analyzed = 30)
		 Baseline anxiety score, M (SD) = 1.62 (0.15)
		 End of treatment anxiety score, M (SD) = 0.90 (0.15)
		 Between group difference, d (95% CI) = 0.89 (0.36 to 1.42)
		• P < 0.001
		Results of mean stress score measured by DASS-21 from baseline (n analyzed = 96) and end of treatment (n analyzed = 30)
		 Baseline stress score, M (SD) = 1.94 (0.10)
		 End of treatment stress score, M (SD) = 1.18 (0.10)
		 Between group difference, d (95% CI) = 1.14 (0.85 to 1.98)
		• P < 0.001
	McClelland et al., (2018) ⁷	Results of mean DASS-21 score from all participants from the FREED cohort (n analyzed = 51 at baseline [T1]; 37 at 3 months [T2]; 33 at 6 months [T3]; 26 at 12 months [T4])
		• T1 score, M (SD) = 32.7 (13.7)
		• T2 score, M (SD) = 24.3 (15.5)
		• T3 score, M (SD) = 21.1 (14.6)
		• T4 score, M (SD) = 23.0 (14.0)
		Mean change in DASS-21 score from T1 (n analyzed = 51) to T2 (n analyzed = 37) of all participants from the FREED cohort
		• M (95% CI) = -9.09 (-14.94 to -3.25)
		• P = 0.001
		Mean change in DASS-21 score from T1 (n analyzed = 51) to T3 (n analyzed = 33) of all participants from the FREED cohort
		• M (95% CI) = -12.21 (-18.24 to -6.17)
		• P = 0.001
		Mean change in DASS-21 score from T1 (n analyzed = 51) to T4 (n analyzed = 26) of all participants from the FREED cohort
		• M (95% CI) = -12.33 (-18.92 to -5.74)
		• P = 0.001
		Mean change in DASS-21 score from T3 (n analyzed = 33) to T4 (n analyzed = 26) of all participants from the FREED cohort



Outcome	Study citation	Detailed findings
		• M (95% Cl) = -0.12 (-5.49 to -5.27)
		• P = 1.00
Expressed emotion	Austin et al., (2022) ²	Results of all participants from the FREED cohort (n analyzed = 278 at baseline [T1]; 216 at 3 months [T2]; 180 at 6 months [T3]; 175 at 12 months [T4])
		 LEE score MD (95% CI) at T1 vs T2; SE (P value) = -2.38(-3.65 to -1.11); 0.65 (P < 0.001)
		 LEE score MD (95% CI) at T2 vs T3; SE (P value) = -0.77 (-2.16 to 0.63); 0.71 (P = 0.28)
		 LEE score MD (95% CI) at T3 vs T4; SE (P value) = -0.87 (-2.34 to 0.61); 0.75 (P = 0.25)
		 LEE score MD (95% CI) at T1 vs T4; SE (P value) = -4.02 (-5.64 to -2.39); 0.82 (P < 0.001)
	McClelland et al., (2018) ⁷	Results of mean LEE score from all participants from the FREED cohort (n analyzed = 51 at baseline [T1]; 37 at 3 months [T2]; 31 at 6 months [T3]; 26 at 12 months [T4])
		• T1 score, M (SD) = 17.3 (11.0)
		• T2 score, M (SD) = 14.9 (9.9)
		• T3 score, M (SD) = 12.0 (7.4)
		• T4 score, M (SD) = 12.2 (12.3)
		Mean change in LEE score from T1 (n analyzed = 51) to T2 (n analyzed = 37) of all participants from the FREED cohort
		• M (95% Cl) = -1.45 (-4.96 to -2.06)
		• P = 1.00
		Mean change in LEE score from T1 (n analyzed = 51) to T3 (n analyzed = 31) of all participants from the FREED cohort
		• M (95% CI) = −3.52 (−7.35 to 0.32)
		• P = 0.088
		Mean change in LEE score from T1 (n analyzed = 51) to T4 (n analyzed = 26) of all participants from the FREED cohort
		• M (95% Cl) = -3.86 (-8.17 to -0.46)
		• P = 0.102
		Mean change in LEE score from T3 (n analyzed = 31) to T4 (n analyzed = 26) of all participants from the FREED cohort
		• M (95% CI) = -0.34 (-4.66 to 3.98)
		• P = 1.00
Function and wellbeing	Austin et al., (2022) ²	Results of all participants from the FREED cohort (n analyzed = 275 at baseline [T1]; 216 at 3 months [T2]; 178 at 6 months [T3]; 175 at 12 months [T4])
		 PSYCHLOPS score MD (95% CI) at T1 vs T2; SE (P value) = −3.79 (−4.35 to −3.24); 0.28 (P < 0.001)
		 PSYCHLOPS score MD (95% CI) at T2 vs T3; SE (P value) = -1.42 (-22.03 to -0.81); 0.31 (P = 0.28)
		 PSYCHLOPS score MD (95% CI) at T3 vs T4; SE (P value) = -1.71 (-2.35



Outcome	Study citation	Detailed findings
		to -1.07); 0.33 (P < 0.001) • PSYCHLOPS score MD (95% CI) at T1 vs T4; SE (P value) = -6.92 (-7.67 to -6.17); 0.38 (P < 0.001)

CIA = Clinical Impairment Assessment; CORE-10/OM = Clinical Outcomes in Routine Evaluation-10/Outcome Measure; DASS-21 = Depression, Anxiety and Stress Scale-21; FREED = First Episode Rapid Early Intervention for Eating Disorder; LEE = Level of Expressed Emotion Scale; M = mean; MD = mean difference; PSYCHLOPS = Psychological Outcome Profiles; SD = standard deviation; SE = standard error; vs = versus.

Table 9: Summary of Detailed Findings for Social Outcomes

Outcome	Study citation	Detailed finding
Work and social adjustment	Austin et al., (2022) ²	Results of all participants from the FREED cohort (n analyzed = 278 at baseline [T1]; 216 at 3 months [T2]; 182 at 6 months [T3]; 175 at 12 months [T4])
		 WSAS score MD (95% CI) at T1 vs T2; SE (P value) = -3.14 (-4.19 to -2.09); 0.54 (P < 0.001)
		 WSAS score MD (95% CI) at T2 vs T3; SE (P value) = -2.94 (-4.09 to -1.79); 0.58 (P < 0.001)
		 WSAS score MD (95% CI) at T3 vs T4; SE (P value) = -2.07 (-3.29 to -0.86); 0.62 (P < 0.001)
		 WSAS score MD (95% CI) at T1 vs T4; SE (P value) = -8.15 (-9.67 to -6.62); 0.77 (P < 0.001)
	McClelland et al., (2018) ⁷	Results of mean WSAS score from all participants from the FREED cohort (n analyzed = 51 at baseline [T1]; 36 at 3 months [T2]; 32 at 6 months [T3]; 26 at 12 months [T4])
		• T1 score, M (SD) = 21.0 (9.7)
		• T2 score, M (SD) = 18.1 (9.7)
		• T3 score, M (SD) = 14.5 (10.5)
		• T4 score, M (SD) = 11.8 (10.3)
		Mean change in WSAS score from T1 (n analyzed = 51) to T2 (n analyzed = 36) of all participants from the FREED cohort
		• M (95% CI) = −2.87 (−7.07 to 1.34)
		• P = 0.354
		Mean change in WSAS score from T1 (n analyzed = 51) to T3 (n analyzed = 32) of all participants from the FREED cohort
		• M (95% CI) = −7.16 (−11.74 to −2.58)
		• P = 0.001
		Mean change in WSAS score from T1 (n analyzed = 51) to T4 (n analyzed = 26) of all participants from the FREED cohort
		• M (95% CI) = −10.21 (−15.50 to −2.58)
		• P = 0.001
		Mean change in WSAS score from T3 (n analyzed = 32) to T4 (n analyzed = 26) of all participants from the FREED cohort
		• M (95% CI) = −3.04 (−8.13 to 2.05)
		• Z-score = -1.49



Outcome	Study citation	Detailed finding
		• P = 0.541
		• SES = -0.31

FREED = First Episode Rapid Early Intervention for Eating Disorder; M = mean; MD = mean difference; SD = standard deviation; SE = standard error; vs = versus; WSAS = Work and Social Adjustment Scale.

Table 10: Summary of Detailed Findings for Health Care Utilization Outcomes

Outcome	Study citation	Detailed findings
Wait times	Richards et al., (2021) ⁴	Proportion of all participants from FREED-Up cohort with an attempted engagement call \leq 48 hours
		 AN participants, n/N (%) = 93/101 (92%)
		 BN/BED participants, n/N (%) = 53/59 (90%)
		• OSFED, n/N (%) = 63/74 (85%)
		• All participants, n/N (%) = 209/234 (89%)
		 Between group comparison, P = 0.34
		Proportion of participants diagnosed with optimal conditions from FREED-Up cohort with an attempted engagement call \leq 48 hours
		 AN participants, n/N (%) = 50/54 (93%)
		 BN/BED participants, n/N (%) = 42/47 (89%)
		• OSFED, n/N (%) = 36/42 (86%)
		 All participants, n/N (%) = 128/143 (90%)
		 Between group comparison, P = 0.90
		Proportion of all participants from FREED-Up cohort that received an engagement call ≤ 48 hours
		 AN participants, n/N (%) = 53/100 (53%)
		 BN/BED participants, n/N (%) = 32/66 (49%)
		• OSFED, n/N (%) = 36/75 (48%)
		 All participants, n/N (%) = 121/241 (50%)
		 Between group comparison, P = 0.76
		Proportion of participants diagnosed with optimal conditions from FREED- Up cohort that received an engagement call \leq 48 hours
		 AN participants, n/N (%) = 26/55 (47%)
		 BN/BED participants, n/N (%) = 24/50 (48%)
		• OSFED, n/N (%) = 20/42 (48%)
		 All participants, n/N (%) = 70/147 (48%)
		 Between group comparison, P = 0.31
		Proportion of all participants from FREED-Up cohort that were offered an assessment ≤ 2 weeks
		 AN participants, n/N (%) = 54/104 (52%)
		 BN/BED participants, n/N (%) = 36/63 (57%)
		• OSFED, n/N (%) = 36/78 (46%)
		 All participants, n/N (%) = 126/245 (51%)
		 Between group comparison, P < 0.01



Outcome	Study citation	Detailed findings
		Proportion of participants diagnosed with optimal conditions from FREED- Up cohort that were offered an assessment ≤ 2 weeks
		 AN participants, n/N (%) = 35/55 (64%)
		 BN/BED participants, n/N (%) = 31/48 (65%)
		• OSFED, n/N (%) = 20/42 (48%)
		 All participants, n/N (%) = 86/145 (59%)
		 Between group comparison, P < 0.01
		Proportion of all participants from FREED-Up cohort that received an assessment ≤ 2 weeks or 4 weeks
		 AN participants, n/N (%) = 50/104 (46%) or 78/109 (72%)
		 BN/BED participants, n/N (%) = 30/69 (44%) or 49/69 (71%)
		 OSFED, n/N (%) = 30/81 (37%) or 61/81 (75%)
		 All participants, n/N (%) = 110/259 (43%) or 188/259 (73%)
		 Between group comparison for assessment received ≤ 2 weeks, P = 0.47
		 Comparison to TAU cohort^a for assessment received ≤ 2 weeks, P < 0.001
		Proportion of participants diagnosed with optimal conditions from FREED- Up cohort that received an assessment ≤ 2 weeks or 4 weeks
		 AN participants, n/N (%) = 30/55 (55%) or 45/55 (82%)
		 BN/BED participants, n/N (%) = 28/55 (55%) or 43/51 (84%)
		 OSFED, n/N (%) = 17/43 (40%) or 38/43 (88%)
		 All participants, n/N (%) = 75/149 (50%) or 126/149 (85%)
		 Between group comparison for assessment received ≤ 2 weeks, P < 0.01
		Proportion of all participants from FREED-Up cohort that were offered treatment ≤ 4 weeks
		 AN participants, n/N (%) = 40/100 (40%)
		 BN/BED participants, n/N (%) = 20/63 (32%)
		• OSFED, n/N (%) = 18/76 (24%)
		 All participants, n/N (%) = 78/239 (33%)
		 Between group comparison, P = 0.07
		Proportion of participants diagnosed with optimal conditions from FREED-Up cohort that were offered treatment ≤ 4 weeks
		 AN participants, n/N (%) = 23/52 (44%)
		 BN/BED participants, n/N (%) = 17/46 (37%)
		• OSFED, n/N (%) = 10/42 (24%)
		 All participants, n/N (%) = 50/140 (36%)
		• Between group comparison, P = 0.29
		Proportion of all participants from FREED-Up cohort that received treatment \leq 4 weeks or 8 weeks
		 AN participants, n/N (%) = 28/108 (26%) or 64/108 (59%)
		 BN/BED participants, n/N (%) = 15/69 (22%) or 41/69 (59%)



Outcome	Study citation	Detailed findings
		• OSFED, n/N (%) = 17/79 (22%) or 42/79 (53%)
		 All participants, n/N (%) = 60/256 (23%) or 147/256 (57%)
		 Between group comparison for assessment received ≤ 4 weeks, P = 0.72
		 Comparison to TAU cohort^b for assessment received ≤ 2 weeks, P < 0.001
		Proportion of participants diagnosed with optimal conditions from FREED- Up cohort that received treatment ≤ 4 weeks or 8 weeks
		 AN participants, n/N (%) = 17/54 (32%) or 40/54 (74%)
		 BN/BED participants, n/N (%) = 14/51 (28%) or 35/51 (69%)
		• OSFED, n/N (%) = 10/41 (24%) or 26/41 (63%)
		 All participants, n/N (%) = 41/146 (28%) or 101/146 (69%)
		 Between group comparison for assessment received ≤ 2 weeks, P = 0.04
	Flynn et al., (2020)⁵	Wait time to assessment (weeks) for participants diagnosed with AN, BN, BED, OSFED from the total FREED cohort (n analyzed = 278)
		• AN, M (SD) = 3.27 (2.65)
		• BN, M (SD) = 3.45 (3.10)
		• BED, M (SD) = 3.10 (0.54)
		• OSFED, M (SD) = 4.18 (5.42)
		 Total, M (SD) = 3.58 (3.79)
		Wait time to assessment (weeks) for participants diagnosed with AN, BN, BED, OSFED under optimal conditions from FREED cohort (n analyzed = 157)
		• AN, M (SD) = 2.54 (1.70)
		• BN, M (SD) = 2.40 (1.56)
		• BED, M (SD) = 3.10 (0.54)
		• OSFED, M (SD) = 2.70 (1.77)
		• Total, M (SD) = 2.56 (1.64)
		Wait time to assessment (weeks) for participants diagnosed with AN, BN, BED, OSFED from TAU cohort (n analyzed = 224)
		• AN, M (SD) = 5.41 (5.64)
		• BN, M (SD) = 6.59 (4.80)
		• BED, M (SD) = 14.0 (2.13)
		• OSFED, M (SD) = 11. 50 (19.71)
		 Total, M (SD) = 6.72 (8.70)
		Between group comparison of wait time to assessment (weeks) from total FREED cohort (n = 278) vs TAU cohort (n = 224)
		• P < 0.001
		• 95% CI = -4.28 to -2.00
		Between group comparison of wait time to assessment (weeks) from FREED cohort under optimal conditions (n = 157) vs TAU cohort (n = 224)
		• P < 0.001



Outcome	Study citation	Detailed findings
		● 95% CI = -5.54 to -2.78
		Wait time to treatment (weeks) for participants diagnosed with AN, BN, BED, OSFED from the total FREED cohort (n analyzed = 278)
		• AN, M (SD) = 7.41 (4.78)
		• BN, M (SD) = 7.72 (5.35)
		• BED, M (SD) = 7.24 (3.19)
		• OSFED, M (SD) = 9.27 (3.19)
		• Total, M (SD) = 8.06 (5.73)
		Wait time to treatment (weeks) for participants diagnosed with AN, BN, BED, OSFED under optimal conditions from FREED cohort (n analyzed = 157)
		• AN, M (SD) = 5.81 (2.82)
		• BN, M (SD) = 6.12 (2.77)
		• BED, M (SD) = 7.24 (3.19)
		• OSFED, M (SD) = 7.31 (3.97)
		• Total, M (SD) = 6.36 (3.21)
		Wait time to treatment (weeks) for participants diagnosed with AN, BN, BED, OSFED from TAU cohort (n analyzed = 224)
		• AN, M (SD) = 18.41 (15.36)
		• BN, M (SD) = 21.34 (13.71)
		• BED, M (SD) = 19.54 (3.01)
		• OSFED, M (SD) = 26.80 (22.78)
		• Total, M (SD) = 20.76 (16.60)
		Between group comparison of wait time to treatment (weeks) from total FREED cohort (n = 278) vs TAU cohort (n = 224)
		• P < 0.001
		● 95% CI = -14.86 to -10.54
		Between group comparison of wait time to treatment (weeks) from FREED cohort under optimal conditions (n = 157) vs TAU cohort (n = 224)
		• P < 0.001
		● 95% CI = -17.08 to -11.70
	McClelland et al., $(2018)^7$	Wait time median (days) from referral to assessment for FREED Cohort (n = 56) and TAU cohort (n = 86)
		 FREED cohort, median (IQR) = 42.5 (23 to 66)
		 TAU cohort, median (IQR) = 62 (41 to 98)
		• RR (95% CI) = 0.74 (0.53 to 1.05)
		• P = 0.084
		Wait time median (days) from assessment to treatment for FREED Cohort (n = 56) and TAU cohort (n = 86)
		 FREED cohort, median (IQR) = 20 (11 to 31)
		 TAU cohort, median (IQR) = 34 (16 to 125)
		• RR (95% CI) = 0.34 (0.23 to 0.49)
		• P < 0.001



Outcome	Study citation	Detailed findings
	Brown et al., (2016) ⁸	Mean wait time to assessment (weeks) for all FREED cohort (n analyzed = 51), FREED cohort with minimal gatekeeping (n analyzed = 14), FREED cohort with complex gatekeeping (n analyzed = 37), and TAU cohort (n analyzed = 89)
		• All FREED cohort, M (SD) = 6.44 (5.38)
		 FREED cohort with minimal gatekeeping, M (SD) = 3.67 (3.35)
		 FREED cohort with complex gatekeeping, M (SD) = 7.48 (5.66)
		• TAU cohort, M (SD) = 9.94 (5.87)
		 P < 0.001 for all FREED cohort vs TAU cohort
		 P < 0.001 for FREED cohort with minimal gatekeeping vs TAU cohort
		 P < 0.05 for FREED cohort with complex gatekeeping vs TAU cohort
		Mean wait time to treatment (weeks) for all FREED cohort (n analyzed = 51), FREED cohort with minimal gatekeeping (n analyzed = 14), FREED cohort with complex gatekeeping (n analyzed = 37), and TAU cohort (n analyzed = 65)
		• All FREED cohort, M (SD) = 9.59 (5.78)
		 FREED cohort with minimal gatekeeping, M (SD) = 6.25 (3.63)
		 FREED cohort with complex gatekeeping, M (SD) = 10.86 (5.97)
		• TAU cohort, M (SD) = 19.87 (15.11)
		 P < 0.001 for all FREED cohort vs TAU cohort
		 P < 0.001 for FREED cohort with minimal gatekeeping vs TAU cohort
		 P < 0.001 for FREED cohort with complex gatekeeping vs TAU cohort
		Mean wait time from assessment to treatment (weeks) for all FREED cohort (n analyzed = 51), FREED cohort with minimal gatekeeping (n analyzed = 14), FREED cohort with complex gatekeeping (n analyzed = 37), and TAU cohort (n analyzed = 65)
		 All FREED cohort, M (SD) = 3.16 (2.19)
		 FREED cohort with minimal gatekeeping, M (SD) = 2.58 (1.41)
		 FREED cohort with complex gatekeeping, M (SD) = 3.38 (2.40)
		• TAU cohort, M (SD) = 10.07 (11.70)
		 P < 0.001 for all FREED cohort vs TAU cohort
		 P < 0.001 for FREED cohort with minimal gatekeeping vs TAU cohort
		 P < 0.001 for FREED cohort with complex gatekeeping vs TAU cohort
Service use	Austin et al., (2022) ²	Proportion of treatment completion for FREED cohort (n = 270) vs TAU cohort (n = 157)
		• FREED cohort, n (%) = 189 (70%)
		• TAU cohort, n (%) = 103 (65.6%)
		• P = 0.35
		Number of treatment sessions attended by FREED cohort vs TAU cohort across 12-month follow-up period
		• FREED cohort, M (SD) = 18.64 (12.64)
		• TAU cohort, M (SD) = 16.67 (15.01)
		• P = 0.16



Outcome	Study citation	Detailed findings
		Number of participants requiring addition intensive treatment for FREED cohort (n = 272) vs TAU cohort (n = 169) across 12-month follow-up period
		• FREED cohort, n (%) = 18 (6.6%)
		• TAU cohort, n (%) = 21 (12.4%)
		• P = 0.037
		Number of days in intensive treatment for FREED cohort vs TAU cohort across 12-month follow-up period
		 FREED cohort, M days (SD) = 7.03 (34.55)
		 TAU cohort, M days (SD) = 17.93 (58.39)
		• P = 0.02
	Flynn et al., (2020)⁵	Treatment uptake after assessment for total FREED cohort (n = 278) vs TAU cohort (n = 224)
		 FREED cohort, n (%) = 272 (97.84%)
		• TAU cohort, n (%) = 160 (71.43%)
		• P < 0.01
	Fukutomi et al., (2019) ⁶	Mean number of treatment sessions attended at 24-month follow-up for FREED-AN cohort (n = 22) and TAU-AN cohort (n = 35)
		• FREED-AN, M (SD) = 30.5 (17.0)
		• TAU-AN, M (SD) = 20.5 (15.4)
		Number of participants needing intensive treatment at 24-month follow-up for FREED-AN cohort vs TAU-AN cohort
		• FREED-AN, n/N (%) = 5/22 (23%)
		• TAU-AN, n/N (%) = 9/28 (32%)
		• P = 0.54
	McClelland et al., $(2018)^7$	Number of participants that took up treatment after assessment for FREED cohort vs TAU cohort
		 FREED cohort, n/N (%) = 56/56 (100%)
		 TAU cohort, n/N (%) = 64/86 (74%)
		• P < 0.001
		Median number of sessions attended for FREED cohort (n = 56) vs TAU cohort (n = 64)
		 FREED cohort, median (IQR) = 21.5 (9 to 29.5)
		 TAU cohort, median (IQR) = 16 (8 to 24)
		• RR (95% CI) = 1.16 (0.80 to 1.70)
		Number of participants that completed treatment for FREED cohort and TAU cohort
		 FREED cohort, n/N (%) = 40/56 (71%)
		• TAU cohort, n/N (%) = 45/64 (71%)
		Number of participants that required additional intensive treatment for FREED cohort vs TAU cohort
		• FREED cohort, n/N (%) = 5/56 (8.9%)



Outcome	Study citation	Detailed findings
		 TAU cohort, n/N (%) = 9/64 (14.1%) P = 0.999
	Brown et al., (2016) ⁸	Number of participants that took up treatment after assessment for FREED cohort vs TAU cohort
		 FREED cohort, n/N (%) = 51/51 (100%)
		• TAU cohort, n/N (%) = 65/89 (73%)
		• X ² = 16.60
		• P < 0.001

AN = anorexia nervosa; BED; binge eating disorder; BN = bulimia nervosa; FREED = First Episode Rapid Early Intervention for Eating Disorder; IQR = inter-quartile range; M = mean; NR = not reported; OSFED; other specified feeding or eating disorder; RR = rate ratio; SD = standard deviation; TAU = treatment as usual; vs = versus. No raw data was reported for TAU cohort; only comparative measures were narratively included in the study.

Detailed Findings of Intervention Programs at the Early Phase

Table 11: Summary of Detailed Findings for Eating Disorder Symptomology Outcomes

Outcome	Study citation	Detailed findings
EDI	Godart et al., (2022) ⁹	Between group comparison from all participants with AN from the FT-S with TAU cohort (n = 30) vs TAU (n = 30); 3 years after the end of treatment
		 EDI total score, FT-S with TAU vs TAU; M (SD) = 47.2 (36.9) vs 48.3 (39.1); -0.2 (P = 0.860); absolute effect size (95%CI) = -1.1 (-21.1 to 18.87); relative effect size^a (95%CI) = -0.03 (-0.5 to 0.5)
	Herpertz-Dahlmann et al., (2021) ¹⁰	Results of EDI-2 global score of all participants with AN that received HoT (n analyzed = 22 at admission [T1]; 21 at the start of HoT [T2]; 21 at the end of HoT [T3]; 21 at 1-year follow-up [T4])
		 M (SD) at T1 vs T4; M = 280.68 (53.21) vs 222.42 (52.23)
		• T2 score, M (SD) = 261.71 (57.37)
		• T3 score, M (SD) = 244.90 (52.91)
	Hurst et al., (2019) ¹²	Results of EDI-3 global score of all participants with AN that received FBT with CBT-P (n = 21); at FBT phase one commencement (T1); at FBT phase two and CBT-P commencement (T2); after completion of CBT-P (T3); after FBT with CBT-P completion (T4)
		• M (SD) at T1 vs T2; M = 56.2 (17.6) vs 50.0 (21.8); 1.55 (d = 0.31)
		 M (SD) at T1 vs T3; M = 56.2 (17.6) vs 41.7 (24.2); 3.18 (d = 0.69); P < 0.01
		 M (SD) at T1 vs T4; M = 56.2 (17.6) vs 36.1 (26.5); 3.64 (d = 0.90); P < 0.01
EDE-Q	Herpertz-Dahlmann et al., (2021) ¹⁰	Results of EDE global score of all participants with AN that received HoT (n analyzed = 22 at admission [T1]; 21 at the start of HoT [T2]; 21 at the end of HoT [T3]; 21 at 1-year follow-up [T4])
		 M (SD) at T1 vs T4; M = 4.04 (1.05) vs 1.53 (1.15); P < 0.001
		 T2 score, M (SD) = NR
		• T3 score, M (SD) = 1.72 (1.01)



Outcome	Study citation	Detailed findings
AN symptom remission	Hurst et al., (2019) ¹²	Results of all participants with AN (n = 19) after the completion of FBT with CBT-P
		 Full remission, n (%) = 11 (57%)
		 Partial remission, n (%) = 8 (43%)

AN = anorexia nervosa; CBT-P = cognitive behavioural therapy module on perfectionism; CI = confidence interval; d = effect size, Cohen's d; df = degrees of freedom; ED = eating disorder; EDE-Q = Eating Disorder Examination Questionnaire; EDI = Eating Disorder Inventory; EDI-C = Eating Disorder Inventory– Children's version; FBT = family-based treatment; FT-S = Systemic Family Therapy; HoT = home treatment; M = mean; NR = not reported; SD = standard deviation; TAU = treatment as usual; vs = versus. ^aOdds ratio for categorical variables and Cohen's d for quantitative variables.

Table 12: Summary of Detailed Findings for BMI and/or Menstruation Outcomes

Outcome	Study citations	Detailed findings
BMI score	Godart et al., (2022) ⁹	 Between group comparison of BMI score of all participants with AN from the FT-S with TAU cohort (n = 30) vs TAU (n = 30); 3 years after the end of treatment FT-S with TAU vs TAU; M (SD) = 18.61 (2.13) vs 17.91 (2.72); 1.2 (P = 0.268); absolute effect size (95%CI) = 0.706 (-0.56 to 1.97); relative effect size^a (95%CI) = 0.288 (-0.219 to 0.797)
	Herpertz-Dahlmann et al., (2021) ¹⁰	Results of BMI score of all participants with AN that received HoT (n analyzed = 22 at admission [T1]; 21 at the start of HoT [T2]; 21 at the end of HoT [T3]; 21 at 1-year follow-up [T4]) • M (SD) at T1 vs T4; M = 16.26 (1.15) vs 19.72 (1.32); P < 0.001 • T2 score, M (SD) = 18.35 (1.01) • T3 score, M (SD) = 19.66 (1.03)
	Rosling et al., (2016) ¹³	 Results from all participants with AN that received FB specialized out-patient service (n analyzed = 31 at baseline [T1]; 1 at 1-year follow-up [T2]) BMI score, M ± SD: T1, M = 15.1 ± 1.22 T2, M = 14.1
BMI percentile	Godart et al., (2022) ⁹	 Between group comparison from all participants with AN from the FT-S with TAU cohort (n analyzed = 30) vs TAU (n analyzed = 30), 3 years after the end of treatment BMI ≥ 10th percentile, FT-S with TAU vs TAU; n (%) = 22/30 (73.3) vs 15/30 (50.0)^b; 3.4 (P = 0.063); absolute effect size (95%CI) = 23.3 (-1.6 to 44.3); relative effect size^a (95%CI) = 2.5 (0.9 to 8.1)
	Herpertz-Dahlmann et al., (2021) ¹⁰	 Results of BMI percentile of all participants with AN that received HoT (n analyzed = 22 at admission [T1]; 21 at the start of HoT [T2]; 21 at the end of HoT [T3]; 21 at 1-year follow-up [T4]) M (SD) at T1 vs T4; M = 3.61(4.36) vs 28.96 (14.98); P < 0.001 T2 BMI percentile, M (SD) = 17.29 (10.56) T3 BMI percentile, M (SD) = 31.19 (10.17)
EBW	Herpertz-Dahlmann et al., (2021) ¹⁰	Results of %EBW° of all participants with AN that received HoT (n analyzed = 22 at admission [T1]; 21 at the start of HoT [T2]; 21 at the end of HoT [T3]; 21 at 1-year follow-up [T4]) • M (SD) at T1 vs T4; M = 77.99 (4.94) vs 92.52 (5.72); P < 0.001



Outcome	Study citations	Detailed findings
		• T2%EBW, M (SD) = 87.68 (4.40)
		• T3%EBW, M (SD) = 93.28 (3.76)
Menstruation	Godart et al., (2022) ⁹	Between group comparison from all participants with AN from the FT-S with TAU cohort (n = 30) vs TAU (n = 30); 3 years after the end of treatment
		 Resumption of menstruation, FT-S with TAU vs TAU; n (%) = 22/30 (73.3) vs 15/30 (50.0)^b; 5.4 (P = 0.020); absolute effect size (95%CI) = 30 (4.8 to 50.4); relative effect size^a (95%CI) = 4.2 (1.2 to 10.2)
	Herpertz-Dahlmann et al., (2021) ¹⁰	Results of menstruation in the last 3 months of all participants with AN that received HoT (n analyzed = 22 at admission [T1]; 21 at the start of HoT [T2]; 21 at the end of HoT [T3]; 21 at 1-year follow-up [T4])
		More than three regular cycles
		• T1, n (%) = 1 (4.5)
		• T2, n (%) = NR
		• T3, n (%) = 8 (38.1)
		• T4, n (%) = 7 (33.3)
		Irregular
		• T1, n (%) = 4 (18.2)
		• T2, n (%) = NR
		• T3, n (%) = 7 (33.3)
		• T4, n (%) = 6 (28.6)
		Amenorrhea
		• T1, n (%) = 17 (77.3)
		• T2, n (%) = NR
		• T3, n (%) = 6 (28.6)
		• T4, n (%) = 4 (19.0)
		Oral contraceptive use
		• T1, n (%) = 0 (0.0)
		• T2, n (%) = NR
		• T3, n (%) = 0 (0.0)
		• T4, n (%) = 4 (19.0)
	Rosling et al., (2016) ¹³	Results of menstrual status of all participants with AN that received FB specialized out-patient service (n = 31 at baseline [T1]; 1 at 1-year follow-up [T2])
		Pre-menarcheal
		• T1, n = 10
		• T2, n = 1
		Secondary amenorrhea
		• T1, n = 19
		• T2, n = 0
		Contraceptives
		• T1, n = 2
		• T2, n = 0



Outcome	Study citations	Detailed findings
MROC/MROAS categories of	Godart et al., (2022) ⁹	Results of outcome categories ^d of all participants with AN from the FT-S with TAU cohort (n analyzed = 30); 3 years after the end of treatment
general outcome		 Good outcome category, n (%) = 17/30 (56.7)
based on BMI and menstrual		 Intermediate outcome category, n (%) = 1/30 (3.3)
function ^d		Results of outcome categories ^c of all participants with AN from the TAU cohort (n analyzed = 29), 3 years after the end of treatment
		 Good outcome category, n (%) = 7/29 (24.1)
		 Intermediate outcome category, n = 2/29
		Between group comparison of all participants with AN from the FT-S with TAU cohort (n analyzed = 30) vs TAU (n analyzed = 29); 3 years after the end of treatment
		 Good/intermediate outcome category, FT-S with TAU vs TAU; n (%) = 18/30 (60.0) vs 9/29 (31.0); 5.0 (P = 0.026); absolute effect size (95%CI) = 28.9 (3.6 to 49.6); relative effect size^a (95%CI) = 3.8 (1.1 to 9.7)
	Rosling et al., (2016) ¹³	Results of outcome categories ^d of all participants with AN from the FB specialized out-patient service cohort (n = 29); 1 at 1-year follow-up
		 Good outcome category, n (%) = 13 (45)

AN = anorexia nervosa; BMI = body mass index; CI = confidence interval; df = degrees of freedom; EBW = expected body weight; EDI = Eating Disorder Inventory; FB = family-based; FBT = family-based treatment; FT-S = Systemic Family Therapy; HoT = home treatment; M = mean; MROC = Morgan and Russell Outcome Categories; MROAS = Morgan-Russell Outcome Assessment Schedule; NR = not reported; SD = standard deviation; TAU = treatment as usual; vs = versus. ^aOdds ratio for categorical variables and Cohen's d for quantitative variables.

^bIndirect clinical data.

°%EBW is calculated as BMI/50th BMI percentile × 100.

 d Good outcome category: BMI > 10th percentile and regular menstruation; Intermediate outcome category: BMI > 10th percentile but amenorrhea (i.e., the absence of menstruation for at least the past three months); Poor outcome category: BMI < 10th percentile and/or presence of bulimic symptoms. A binary outcome contrasting a Good or Intermediate vs. Poor outcome was used.

Table 13: Summary of Detailed Findings for Psychological Impact Outcomes

Outcome	Study citation	Detailed findings
Psychological distress	Godart et al., (2022) ⁹	Results from all participants with AN from the FT-S with TAU cohort (n = 30) vs TAU (n = 30); 3 years after the end of treatment
		 SCL-90-R/GSI score, FT-S with TAU vs TAU; M (SD) = 0.63 (0.64) vs 0.59 (0.63); -0.3 (df = 55, P = 0.807); absolute effect size (95%CI) = 0.04 (-0.29 to 0.38); relative effect size^a (95%CI) = -0.8 (-1.4 to -0.3)
		 SCL-90-R/PST score, FT-S with TAU vs TAU; M (SD) = 29.8 (21.4) vs 29.1 (20.1); -0.1 (df = 55, P = 0.902); absolute effect size (95%CI) = 0.68 (-10.3 to 11.7); relative effect size^a (95%CI) = 0.03 (-0.5 to 0.5)
		 SCL-90-R/PSDI score, FT-S with TAU vs TAU; M (SD) = 0.02 (0.01) vs 0.02 (0.01); -1.3 (df = 55, P = 0.362); absolute effect size (95%CI) = 0.001 (-0.002 to 0.005); relative effect size^a (95%CI) = 0.24 (-0.3 to 0.7)
Depression	Herpertz-Dahlmann et al., (2021) ¹⁰	Results of BDI-II sum score of all participants with AN that received HoT (n analyzed = 22 at admission [T1]; 21 at the start of HoT [T2]; 21 at the end of HoT [T3]; 21 at 1-year follow-up [T4])
		 M (SD) at T1 vs T4; M = 21.50 (11.25) vs 10.29 (9.71); P = 0.003
		• T2 score, M (SD) = 14.95 (11.14)
		• T4 score, M (SD) = 11.00 (9.70)



Outcome	Study citation	Detailed findings
Perfectionism	Hurst et al., (2019) ¹²	Results of all participants with AN that received FBT with CBT-P (n = 21); at FBT phase one commencement [T1]; at FBT phase two and CBT-P commencement [T2]; after completion of CBT-P [T3]; after FBT with CBT-P completion [T4] EDI perfectionism score
		• M (SD) at T1 vs T2; M = 14.3 (4.9) vs 14.0 (6.2); 0.29 (d = 0.05)
		• M (SD) at T1 vs T3; M = 14.3 (4.9) vs 11.0 (6.0); 3.01 (d = 0.60); P < 0.01
		• M (SD) at T1 vs T4; M = 14.3 (4.9) vs 10.2 (6.7); 3.02 (d = 0.70); P < 0.01
		EDI overcontrol score
		 M (SD) at T1 vs T2; M = 29.3 (11.1) vs 28.6 (12.7); 0.31 (d = 0.06)
		• M (SD) at T1 vs T3; M = 29.3 (11.1) vs 23.7 (14.5); 2.20 (d = 0.43), P < 0.05
		• M (SD) at T1 vs T4; M = 29.3 (11.1) vs 21.0 (16.0); 2.7 (d = 0.60), P < 0.05
		CAPS self-oriented perfectionism score
		 M (SD) at T1 vs T2; M = 47.9 (8.5) vs 46.3 (9.8); 0.99 (d = 0.17)
		• M (SD) at T1 vs T3; M = 47.9 (8.5) vs 43.3 (11.4); 2.61 (d = 0.46); P < 0.05
		 M (SD) at T1 vs T4; M = 47.9 (8.5) vs 40.1 (12.0); 3.3 (d = 0.76); P < 0.01
		CAPS socially prescribed perfectionism score
		 M (SD) at T1 vs T2; M = 28.0 (8.3) vs 29.7 (8.4); -1.06 (d = 0.20)
		 M (SD) at T1 vs T3; M = 28.0 (8.3) vs 28.5 (9.5); -0.24 (d = 0.06)
		• M (SD) at T1 vs T4; M = 28.0 (8.3) vs 26.0 (10.4); 0.82 (d = 0.21)

AN = anorexia nervosa; BDI-II = Beck Depression Inventory-II; CAPS = Child and Adolescent Perfectionism Scale; CBT-P = cognitive behavioural therapy module on perfectionism; CI = confidence interval; d = effect size, Cohen's d; df = degrees of freedom; FB = family-based; FBT = family-based treatment; FT = family therapy; FT-S = Systemic Family Therapy; GSI = Global Severity Index; HoT = home treatment; M = mean; PSDI = Positive Symptom Distress Index; PST = Positive Symptom Total; SD = standard deviation; SCL-90-R = Symptom Check List 90-Revised; TAU = treatment as usual; vs = versus.

Table 14: Summary of Detailed Findings for Social Outcomes

Outcome	Study citation	Detailed finding
School attendance	Rosling et al., (2016) ¹³	Results from all participants with AN (n = 31) that received FB specialized out-patient service; at 1-year follow-up • Back to school on a full-time basis, n (%) = 27 (93%)
Social Adjustment	Godart et al., (2012) ¹⁴	Between group comparison of SAS global score of all participants with AN from the FT with TAU cohort (n = 30) vs TAU (n = 30 at baseline [T1], 29 at 8 months of follow-up [T2])
		 T1, FT with TAU vs TAU; M (SD) = 2.6 (0.6) vs 2.6 (0.6); -0.11 (P = 0.91) T2, FT with TAU vs TAU; M (SD) = 2.0 (0.8) vs 2.0 (0.8); -0.23 (P = 0.82); absolute effect size (95%CI) = 0; relative effect size^a (95%CI) = 0 (-0.29 to 0.29)

AN = anorexia nervosa; CI = confidence interval; df = degrees of freedom; FB = family-based; FT = family therapy; M = mean; SAS = Social Adjustment Scale; SD = standard deviation; TAU = treatment as usual; vs = versus.

^aOdds ratio for categorical variables and Cohen's d for quantitative variables.



Outcome	Study citation	Detailed findings
Service use	Godart et al., (2022) ⁹	Results from all participants with AN from the FT-S with TAU cohort (n = 30) vs TAU (n = 30); 3 years after the end of treatment
		 Psychiatric re-hospitalizations, FT-S with TAU vs TAU; n (%) = 13/30 (43.3) vs 18/30 (60)^a; 1.7 (P = 0.196); absolute effect size (95%CI) = 16.7 (8.2 to 38.8); relative effect size^b (95%CI) = 1.05 (0.18 to 1.4)
		• Re-hospitalization for AN, FT-S with TAU vs TAU; n (%) = $11/30$ (36.7) vs $15/30$ (50) ^a ; 1.1 (P = 0.297); absolute effect size (95%Cl) = 13.3 (-11.2 to 35.7); relative effect size ^b (95%Cl) = 0.6 (0.2 to 1.6)
	Rosling et al., (2016) ¹³	Results from all participants with AN that received FB specialized out-patient service (n = 29); at first year of treatment (T1); 1-year follow-up (T2)
		= T1 - 14
		• T2 n = 0
		Treated at EDI only in out-natient during the year
		• T1, n = 15
		• T2, n = 1
	Coelho et al., (2019) ¹¹	Results of all participants with AN or other specified/unspecified eating disorder that received FBT (n analyzed = 62)
		 Number of days of FBT, Mdn (IQR) = 207 (21 to 1,556)
		 Number of participants that completed FBT, n (%) = 25 (40.3)
		 Number of participants that required continued ED treatment, n (%) = 25 (40.3)
		 Number of participants that required additional intensive treatment, n (%) = 13 (21)
		• Number of participants that required discontinuation of FBT, n (%) = 5 (8.1)
Treatment satisfaction	Herpertz-Dahlmann et al., (2021) ¹⁰	Results of ZUF-8 score of all participants with AN that received HoT (n analyzed = 21 at the start of HoT [T2]; 21 at the end of HoT [T3])
		• T2 score, M (SD) = 1.77 (0.39)
		• T3 score, M (SD) = 1.64 (0.41)

Table 15: Summary of Detailed Findings for Health Care Utilization Outcomes

AN = anorexia nervosa; CI = confidence interval; df = degrees of freedom; ED = eating disorder; EDU = Eating Disorder Unit; FB = family-based; FBT = family-based treatment; FT-S = Systemic Family Therapy; HoT = home treatment; IQR = inter-quartile range; M = mean; Mdn = median; NR = not reported; SD = standard deviation; TAU = treatment as usual; vs = versus.

alndirect clinical data.

^bOdds ratio for categorical variables and Cohen's d for quantitative variables.

Table 16: Summary of Detailed Findings for Global Functioning Outcomes

Outcome	Study citation	Detailed findings
Quality of life	Herpertz-Dahlmann et al., (2021) ¹⁰	Results of Kidscreen-27 score of all participants with AN that received HoT (n analyzed = 22 at admission [T1]; 21 at the start of HoT [T2]; 21 at the end of HoT [T3]; 21 at 1-year follow-up [T4]) Physical well-being • M (SD) at T1 vs T4; M = 30.04 (10.75) vs 47.82 (11.51); P < 0.001

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Outcome	Study citation	Detailed findings
		• T2 score, M (SD) = NR
		• T3 score, M (SD) = 44.27 (9.32)
		Psychological well-being
		 M (SD) at T1 vs T4; M = 29.05 (17.46) vs 44.67 (13.76); P = 0.010
		• T2 score, M (SD) = NR
		• T3 score, M (SD) = 40.16 (12.27)
		Parent relations and autonomy
		 M (SD) at T1 vs T4; M = 52.34 (7.85) vs 56.56 (8.75); P = 0.023
		 T2 score, M (SD) = NR
		• T3 score, M (SD) = 53.77 (7.82)
		Social support and peers
		 M (SD) at T1 vs T4; M = 41.95 (11.86) 51.54 (11.47); P = 0.008
		 T2 score, M (SD) = NR
		• T3 score, M (SD) = 46.19 (8.22)
		School environment
		• M (SD) at T1 vs T4; M = 50.14 (9.61) vs 56.48 (10.68); P = 0.078
		• T2 score, M (SD) = NR
		• T3 score, M (SD) = 54.60 (8.49)
General outcomes on socioeconomic status, food intake, menstrual state, mental state and psychosexual state	Godart et al., (2022) ⁹	Results of GOAS Global Score of all participants with AN from the FT-S with TAU cohort (n = 30) vs TAU (n = 30), 3 years after the end of treatment
		 FT-S with TAU vs TAU; M (SD) = 8.8 (2.8) vs 8.4 (2.4); 1.14 (P = 0.252); absolute effect size (95%CI) = 0.47 (-0.908 to 1.85); relative effect size^a (95%CI) = 0.177 (-0.33 to 0.689)
	Herpertz-Dahlmann et al., (2021) ¹⁰	Results of MROAS global score of all participants with AN that received HoT (n analyzed = 22 at admission [T1]; 21 at the start of HoT [T2]; 21 at the end of HoT [T3]; 21 at 1-year follow-up [T4])
		 M (SD) at T1 vs T4; MD = 4.28 (1.39) vs 8.72 (1.60); P < 0.001
		• T2 score, M (SD) = NR
		• T3 score, M (SD) = 7.97 (1.67)

AN = anorexia nervosa; CI = confidence interval; df = degrees of freedom; FT-S = Systemic Family Therapy; HoT = home treatment; GOAS = Global Outcome Assessment Schedule; M = mean; MRAOS = Morgan and Russell Average Outcome Score; NR = not reported; SD = standard deviation; TAU = treatment as usual; vs = versus. ^aOdds ratio for categorical variables and Cohen's d for quantitative variables.



Selection of Included Cost-Effectiveness Studies





List of Excluded Publications From Clinical Review and Reasons for Exclusion

The citations provided in this list are studies that were excluded after full-text review by 2 independent reviewers as part of the Clinical Review (in reverse chronological and alphabetical order).

Irrelevant Population (n = 87)

- Billman MG, Forrest LN, Johnson M, et al. Preliminary effectiveness of a cognitive-behavioral, family-centered partial hospitalization program for children and adolescents with avoidant/restrictive food intake disorder. *Int J Eat Disord*. 2022;55(11):1621-1626. PubMed
- D'Adamo L, Monterubio G, Claire A, et al. Evaluating a Combined Intervention for Binge-Type Eating Disorders and Weight Loss for Young Adults. *Obesity*. 2022;30(152):2022-11.
- Kaa BS, Bunemann JMN, Clausen L. A benchmark study of a combined individual and group anorexia nervosa therapy program. Nord J Psychiatry. 2022;():1-8.
- Rom S, Miskovic-Wheatley J, Barakat S, Aouad P, Fuller-Tyszkiewicz M, Maguire S. Evaluating the feasibility and potential efficacy of a brief eTherapy for binge-eating disorder: A pilot study. Int J Eat Disord. 2022;55(11)():1614-1620.
- Sonntag M, Russell J. The mind-in-mind study: A pilot randomised controlled trial that compared modified mentalisation based treatment with supportive clinical management for patients with eating disorders without borderline personality disorder. *European Eating Disorders Review*. 2022;30(3)():206-220.
- Ciao AC, Munson BR, Pringle KD, et al. Inclusive dissonance-based body image interventions for college students: Two randomizedcontrolled trials of the EVERYbody Project. *J Consult Clin Psychol*. 2021;89(4):301-315. <u>PubMed</u>
- Darling KE, Rancourt D, Evans E, Ranzenhofer LM, Jelalian E. Adolescent weight management intervention in a nonclinical setting: Changes in eating-related cognitions and depressive symptoms. *J Dev Behav Pediatr*. 2021;42(7):579-587. <u>PubMed</u>
- Eik-Nes TT, Vrabel K, Raman J, Clark MR, Berg KH. A Group Intervention for Individuals With Obesity and Comorbid Binge Eating Disorder: Results From a Feasibility Study. *Front Endocrinol (Lausanne)*. 2021;12():738856.
- Volkert VM, Burrell L, Berry RC, et al. Intensive multidisciplinary feeding intervention for patients with avoidant/restrictive food intake disorder associated with severe food selectivity: An electronic health record review. *Int J Eat Disord*. 2021;54(11):1978-1988. PubMed
- Wade TD, Ghan C, Waller G. A randomized controlled trial of two 10-session cognitive behaviour therapies for eating disorders: An exploratory investigation of which approach works best for whom. *Behaviour Research and Therapy Vol 146 2021*, *ArtID* 103962. 2021;146():.
- Walker DC, Donahue JM, Heiss S, et al. Rapid response is predictive of treatment outcomes in a transdiagnostic intensive outpatient eating disorder sample: a replication of prior research in a real-world setting. *Eating and Weight Disorders*. 2021;26(5) ():1345-1356.
- Yu Z, Roberts B, Snyder J, et al. A Pilot Study of a Videoconferencing-Based Binge Eating Disorder Program in Overweight or Obese Females. *Telemed J E Health*. 2021;27(3):330-340. <u>PubMed</u>
- Ziser K, Rheindorf N, Keifenheim K, et al. Motivation-Enhancing Psychotherapy for Inpatients With Anorexia Nervosa (MANNA): A Randomized Controlled Pilot Study. *Front Psychiatr.* 2021;12():632660.
- Beintner I, Hutter K, Gramatke K, Jacobi C. Combining day treatment and outpatient treatment for eating disorders: findings from a naturalistic setting. *Eat Weight Disord*. 2020;25(2):519-530. <u>PubMed</u>
- Brennan MA, Whelton WJ, Sharpe D. Benefits of yoga in the treatment of eating disorders: Results of a randomized controlled trial. *Eat.* 2020;28(4):438-457. <u>PubMed</u>



- Burnette CB, Mazzeo SE. An uncontrolled pilot feasibility trial of an intuitive eating intervention for college women with disordered eating delivered through group and guided self-help modalities. *Int J Eat Disord*. 2020;53(9):1405-1417. PubMed
- Fitzsimmons-Craft EE, Taylor CB, Graham AK, et al. Effectiveness of a Digital Cognitive Behavior Therapy-Guided Self-Help Intervention for Eating Disorders in College Women: A Cluster Randomized Clinical Trial. JAMA Network Open. 2020;3(8):e2015633. <u>PubMed</u>
- Ranzenhofer LM, Wilhelmy M, Hochschild A, Sanzone K, Walsh BT, Attia E. Peer mentorship as an adjunct intervention for the treatment of eating disorders: A pilot randomized trial. *Int J Eat Disord*. 2020;53(5):497-509. <u>PubMed</u>
- Shimshoni Y, Silverman WK, Lebowitz ER. SPACE-ARFID: A pilot trial of a novel parent-based treatment for avoidant/restrictive food intake disorder. *Int J Eat Disord*. 2020;53(10):1623-1635. PubMed
- Cachelin FM, Gil-Rivas V, Palmer B, et al. Randomized controlled trial of a culturally-adapted program for Latinas with binge eating. *Psychol Serv.* 2019;16(3):504-512. <u>PubMed</u>
- Enander J, Ljotsson B, Anderhell L, et al. Long-term outcome of therapist-guided internet-based cognitive behavioural therapy for body dysmorphic disorder (BDD-NET): a naturalistic 2-year follow-up after a randomised controlled trial. *BMJ Open*. 2019;9(1):e024307. <u>PubMed</u>
- Jenkins PE, Morgan C, Houlihan C. Outpatient CBT for Underweight Patients with Eating Disorders: Effectiveness Within a National Health Service (NHS) Eating Disorders Service. *Behav Cogn Psychother*. 2019;47(2):217-229. <u>PubMed</u>
- Keizer A, Engel MM, Bonekamp J, Van Elburg A. Hoop training: a pilot study assessing the effectiveness of a multisensory approach to treatment of body image disturbance in anorexia nervosa. *Eat Weight Disord*. 2019;24(5):953-958. PubMed
- Pinto-Gouveia J, Carvalho SA, Palmeira L, et al. Incorporating psychoeducation, mindfulness and self-compassion in a new programme for binge eating (BEfree): Exploring processes of change. J Health Psychol. 2019;24(4):466-479. PubMed
- Stice E, Rohde P, Shaw H, Gau JM. Randomized trial of a dissonance-based group treatment for eating disorders versus a supportive mindfulness group treatment. *J Consult Clin Psychol*. 2019;87(1):79-90. <u>PubMed</u>
- Tantillo M, McGraw JS, Lavigne HM, Brasch J, Le Grange D. A pilot study of multifamily therapy group for young adults with anorexia nervosa: Reconnecting for recovery. *Int J Eat Disord*. 2019;52(8):950-955. PubMed
- Signorini R, Sheffield J, Rhodes N, Fleming C, Ward W. The Effectiveness of Enhanced Cognitive Behavioural Therapy (CBT-E): A Naturalistic Study within an Out-Patient Eating Disorder Service. *Behav Cogn Psychother*. 2018;46(1):21-34. <u>PubMed</u>
- Diedrich A, Schlegl S, Greetfeld M, Fumi M, Voderholzer U. Intensive inpatient treatment for bulimia nervosa: Statistical and clinical significance of symptom changes. *Psychother*. 2018;28(2):297-312. <u>PubMed</u>
- Green MA, Kroska A, Herrick A, et al. A preliminary trial of an online dissonance-based eating disorder intervention. *Eat Behav*. 2018;31():88-98.
- Gumz A, Weigel A, Wegscheider K, Romer G, Lowe B. The psychenet public health intervention for anorexia nervosa: a pre-postevaluation study in a female patient sample. *Prim Health Care Res Dev.* 2018;19(1):42-52. <u>PubMed</u>
- Setsu R, Asano K, Numata N, et al. A single-arm pilot study of guided self-help treatment based cognitive behavioral therapy for bulimia nervosa in Japanese clinical settings. *BMC Res Notes*. 2018;11(1):257. <u>PubMed</u>
- Chen EY, Cacioppo J, Fettich K, et al. An adaptive randomized trial of dialectical behavior therapy and cognitive behavior therapy for binge-eating. *Psychol Med.* 2017;47(4):703-717. PubMed
- Pacanowski CR, Diers L, Crosby RD, Neumark-Sztainer D. Yoga in the treatment of eating disorders within a residential program: A randomized controlled trial. *Eat.* 2017;25(1):37-51. <u>PubMed</u>
- Rose C, Waller G. Cognitive-behavioral therapy for eating disorders in primary care settings: Does it work, and does a greater dose make it more effective?. *Int J Eat Disord*. 2017;50(12):1350-1355. PubMed
- Enander J, Andersson E, Mataix-Cols D, et al. Therapist guided internet based cognitive behavioural therapy for body dysmorphic disorder: single blind randomised controlled trial. *BMJ*. 2016;352():i241.
- Freudenberg C, Jones RA, Livingston G, Goetsch V, Schaffner A, Buchanan L. Effectiveness of individualized, integrative outpatient treatment for females with anorexia nervosa and bulimia nervosa. *Eat.* 2016;24(3):240-54. <u>PubMed</u>



- Mac Neil BA, Leung P, Nadkarni P, Stubbs L, Singh M. A pilot evaluation of group-based programming offered at a Canadian outpatient adult eating disorders clinic. *Eval Program Plann.* 2016;58():35-41.
- McIntosh VVW, Jordan J, Carter JD, et al. Psychotherapy for transdiagnostic binge eating: A randomized controlled trial of cognitivebehavioural therapy, appetite-focused cognitive-behavioural therapy, and schema therapy. *Psychiatry Res.* 2016;240():412-420.
- Turner H, Marshall E, Wood F, Stopa L, Waller G. CBT for eating disorders: The impact of early changes in eating pathology on later changes in personality pathology, anxiety and depression. *Behav Res Ther*. 2016;77():1-6.
- van Heerden HJ, Razlog R, Pellow J. Pilot Study on the Homeopathic Treatment of Binge Eating in Males. *Altern Ther Health Med.* 2016;22 Suppl 1():8-13.
- Wagner B, Nagl M, Dolemeyer R, et al. Randomized Controlled Trial of an Internet-Based Cognitive-Behavioral Treatment Program for Binge-Eating Disorder. *Behav Ther.* 2016;47(4):500-14. <u>PubMed</u>
- Wagner R, MacCaughelty C, Rufino K, et al. Effectivenes of a track-based model for treating eating disorders in a general psychiatric hospital. *Bull Menninger Clin.* 2016;80(1):49-59. PubMed
- Dimitropoulos G, Farquhar JC, Freeman VE, Colton PA, Olmsted MP. Pilot study comparing multi-family therapy to single family therapy for adults with anorexia nervosa in an intensive eating disorder program. *European Eating Disorders Review*. 2015;23(4):294-303. PubMed
- Knott S, Woodward D, Hoefkens A, Limbert C. Cognitive Behaviour Therapy for Bulimia Nervosa and Eating Disorders Not Otherwise Specified: Translation from Randomized Controlled Trial to a Clinical Setting. *Behav Cogn Psychother*. 2015;43(6):641-54. <u>PubMed</u>
- MacDonald DE, Trottier K, McFarlane T, Olmsted MP. Empirically defining rapid response to intensive treatment to maximize prognostic utility for bulimia nervosa and purging disorder. *Behav Res Ther.* 2015;68():48-53.
- Schlegel S, Hartmann A, Fuchs R, Zeeck A. The Freiburg sport therapy program for eating disordered outpatients: a pilot study. *Eat Weight Disord*. 2015;20(3):319-27. PubMed
- Schmidt U, Magill N, Renwick B, et al. The Maudsley Outpatient Study of Treatments for Anorexia Nervosa and Related Conditions (MOSAIC): Comparison of the Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA) with specialist supportive clinical management (SSCM) in outpatients with broadly defined anorexia nervosa: A randomized controlled trial. *J Consult Clin Psychol.* 2015;83(4):796-807. PubMed
- Stice E, Rohde P, Butryn M, Menke KS, Marti CN. Randomized controlled pilot trial of a novel dissonance-based group treatment for eating disorders. *Behav Res Ther.* 2015;65():67-75.
- Turner H, Marshall E, Stopa L, Waller G. Cognitive-behavioural therapy for outpatients with eating disorders: effectiveness for a transdiagnostic group in a routine clinical setting. *Behav Res Ther.* 2015;68():70-5.
- Vander Wal JS, Maraldo TM, Vercellone AC, Gagne DA. Education, progressive muscle relaxation therapy, and exercise for the treatment of night eating syndrome. A pilot study. *Appetite*. 2015;89():136-44.
- Calugi S, El Ghoch M, Conti M, Dalle Grave R. Depression and treatment outcome in anorexia nervosa. *Psychiatry Res*. 2014;218(1-2):195-200. PubMed
- Hotzel K, von Brachel R, Schmidt U, et al. An Internet-based program to enhance motivation to change in females with symptoms of an eating disorder: a randomized controlled trial. *Psychol Med*. 2014;44(9):1947-63. <u>PubMed</u>
- Steinglass JE, Albano AM, Simpson HB, et al. Confronting fear using exposure and response prevention for anorexia nervosa: A randomized controlled pilot study. Int J Eat Disord. 2014;47(2)():174-180.
- Wildes JE, Marcus MD, Cheng Y, McCabe EB, Gaskill JA. Emotion acceptance behavior therapy for anorexia nervosa: a pilot study. *Int J Eat Disord*. 2014;47(8):870-3. PubMed
- Cardi V, Clarke A, Treasure J. The use of guided self-help incorporating a mobile component in people with eating disorders: a pilot study. *European Eating Disorders Review*. 2013;21(4):315-22. <u>PubMed</u>
- Dalle Grave R, Calugi S, Conti M, Doll H, Fairburn CG. Inpatient cognitive behaviour therapy for anorexia nervosa: a randomized controlled trial. *Psychother Psychosom*. 2013;82(6):390-8. <u>PubMed</u>


- deGraft-Johnson A, Fisher M, Rosen L, Napolitano B, Laskin E. Weight gain in an eating disorders day program. *Int J Adolesc Med Health*. 2013;25(2):177-80. PubMed
- Hogdahl L, Birgegard A, Bjorck C. How effective is bibliotherapy-based self-help cognitive behavioral therapy with Internet support in clinical settings? Results from a pilot study. *Eat Weight Disord*. 2013;18(1):37-44. PubMed
- Jones A, Clausen L. The efficacy of a brief group CBT program in treating patients diagnosed with bulimia nervosa: a brief report. Int J Eat Disord. 2013;46(6):560-2. PubMed
- Juarascio A, Shaw J, Forman E, et al. Acceptance and commitment therapy as a novel treatment for eating disorders: an initial test of efficacy and mediation. *Behav Modif.* 2013;37(4):459-89. <u>PubMed</u>
- Lynch TR, Gray KL, Hempel RJ, Titley M, Chen EY, O'Mahen HA. Radically open-dialectical behavior therapy for adult anorexia nervosa: feasibility and outcomes from an inpatient program. *BMC Psychiatry*. 2013;13():293.
- Raykos BC, Watson HJ, Fursland A, Byrne SM, Nathan P. Prognostic value of rapid response to enhanced cognitive behavioral therapy in a routine clinic sample of eating disorder outpatients. *Int J Eat Disord*. 2013;46(8):764-70. <u>PubMed</u>
- Simon W, Lambert MJ, Busath G, et al. Effects of providing patient progress feedback and clinical support tools to psychotherapists in an inpatient eating disorders treatment program: a randomized controlled study. *Psychother*. 2013;23(3):287-300. <u>PubMed</u>
- Stein KF, Corte C, Chen DG, Nuliyalu U, Wing J. A randomized clinical trial of an identity intervention programme for women with eating disorders. *European Eating Disorders Review*. 2013;21(2):130-42. <u>PubMed</u>
- ter Huurne ED, Postel MG, de Haan HA, Drossaert CH, DeJong CA. Web-based treatment program using intensive therapeutic contact for patients with eating disorders: before-after study. *J Med Internet Res*. 2013;15(2):e12. PubMed
- Vaz AR, Conceicao E, Machado PP. Guided self-help CBT treatment for bulimic disorders: effectiveness and clinically significant change. *Psychother*. 2013;23(3):324-32. <u>PubMed</u>
- Zuchova S, Erler T, Papezova H. Group cognitive remediation therapy for adult anorexia nervosa inpatients: first experiences. *Eat Weight Disord*. 2013;18(3):269-73. PubMed
- Jacobi C, Volker U, Trockel MT, Taylor CB. Effects of an Internet-based intervention for subthreshold eating disorders: a randomized controlled trial. *Behav Res Ther.* 2012;50(2):93-9. PubMed
- Hildebrandt T, Loeb K, Troupe S, Delinsky S. Adjunctive mirror exposure for eating disorders: a randomized controlled pilot study. Behav Res Ther. 2012;50(12):797-804. PubMed
- Munsch S, Meyer AH, Biedert E. Efficacy and predictors of long-term treatment success for Cognitive-Behavioral Treatment and Behavioral Weight-Loss-Treatment in overweight individuals with binge eating disorder. *Behav Res Ther*. 2012;50(12):775-85. <u>PubMed</u>
- Watson HJ, Allen K, Fursland A, Byrne SM, Nathan PR. Does enhanced cognitive behaviour therapy for eating disorders improve quality of life?. *European Eating Disorders Review*. 2012;20(5):393-9. <u>PubMed</u>
- Carrard I, Crepin C, Rouget P, Lam T, Golay A, Van der Linden M. Randomised controlled trial of a guided self-help treatment on the Internet for binge eating disorder. *Behav Res Ther.* 2011;49(8):482-91. PubMed
- Carrard I, Fernandez-Aranda F, Lam T, et al. Evaluation of a guided internet self-treatment programme for bulimia nervosa in several European countries. *European Eating Disorders Review*. 2011;19(2):138-49. <u>PubMed</u>
- Catalan-Matamoros D, Helvik-Skjaerven L, Labajos-Manzanares MT, Martinez-de-Salazar-Arboleas A, Sanchez-Guerrero E. A pilot study on the effect of Basic Body Awareness Therapy in patients with eating disorders: a randomized controlled trial. *Clin Rehabil*. 2011;25(7):617-26. <u>PubMed</u>
- Graham L, Walton M. Investigating the use of CD-Rom CBT for bulimia nervosa and binge eating disorder in an NHS adult outpatient eating disorders service. *Behav Cogn Psychother*. 2011;39(4):443-56. <u>PubMed</u>
- Hepworth NS. A mindful eating group as an adjunct to individual treatment for eating disorders: a pilot study. *Eat*. 2011;19(1):6-16. PubMed
- Legenbauer T, Schutt-Stromel S, Hiller W, Vocks S. Predictors of improved eating behaviour following body image therapy: a pilot study. *European Eating Disorders Review*. 2011;19(2):129-37. PubMed



- Clyne C, Latner JD, Gleaves DH, Blampied NM. Treatment of emotional dysregulation in full syndrome and subthreshold binge eating disorder. *Eat*. 2010;18(5):408-24. <u>PubMed</u>
- Shapiro JR, Bauer S, Andrews E, et al. Mobile therapy: Use of text-messaging in the treatment of bulimia nervosa. *Int J Eat Disord*. 2010;43(6)():513-519.
- Carter JC, McFarlane TL, Bewell C, et al. Maintenance treatment for anorexia nervosa: a comparison of cognitive behavior therapy and treatment as usual. *Int J Eat Disord*. 2009;42(3):202-7. PubMed
- Fernandez-Aranda F, Krug I, Jimenez-Murcia S, et al. Male eating disorders and therapy: a controlled pilot study with one year followup. J Behav Ther Exp Psychiatry. 2009;40(3):479-86. PubMed
- Adriaens A, Pieters G, Vancampfort D, Probst M, Vanderlinden J. A cognitive-behavioural program (one day a week) for patients with obesity and binge eating disorder: Short-term follow-up data. *Psihologijske Teme*. 2008;17(2):361-372.
- Dean HY, Touyz SW, Rieger E, Thornton CE. Group motivational enhancement therapy as an adjunct to inpatient treatment for eating disorders: a preliminary study. *European Eating Disorders Review*. 2008;16(4):256-67. PubMed
- Robinson P, Serfaty M. Getting better byte by byte: a pilot randomised controlled trial of email therapy for bulimia nervosa and binge eating disorder. *European Eating Disorders Review*. 2008;16(2):84-93. PubMed
- Schaffner AD, Buchanan LP. Integrating evidence-based treatments with individual needs in an outpatient facility for eating disorders. *Eat.* 2008;16(5):378-92. <u>PubMed</u>

Schooler NR. Solomon C Goldberg, PhD. Neuropsychopharmacology. 2008;33(13):3252.

Treat TA, McCabe EB, Gaskill JA, Marcus MD. Treatment of anorexia nervosa in a specialty care continuum. *Int J Eat Disord*. 2008;41(6):564-72. PubMed

Irrelevant Intervention (n = 106)

- Couturier J, Sami S, Nicula M, et al. Examining the feasibility of a parental self-help intervention for families awaiting pediatric eating disorder services. *Int J Eat Disord*. 2023;56(1):276-281. PubMed
- Moreno R, Buckelew SM, Accurso EC, Raymond-Flesch M. Disparities in access to eating disorders treatment for publicly-insured youth and youth of color: a retrospective cohort study. *Journal of Eating Disorders*. 2023;11(1):10. PubMed
- Moron-Nozaleda MG, Yanez S, Camarneiro RA, et al. Feasibility and acceptability of a hospital-at-home program for adolescents with eating disorders: Making progress in community/family-based treatments. *Int J Eat Disord*. 2023;56(4):790-795. PubMed
- Ortiz AML, Cusack CE, Billman MG, Essayli JH. Baseline symptomatology and treatment outcomes of young adults in a virtual versus in-person partial hospitalization and intensive outpatient program for eating disorders. *Int J Eat Disord*. 2023;24():24.
- Radunz M, Wade TD. Towards an understanding of help-seeking behaviour for disordered eating: Refinement of a barriers to helpseeking measure. *Early Interv Psychiatry*. 2023;17():17.
- Ursumando L, Ponzo V, Monteleone AM, et al. Non-invasive brain stimulation in adolescents with anorexia nervosa: preliminary data of a randomized, double blind, placebo-controlled trial. *Brain Stimul.* 2023;Vol.16(1):251p.
- Van Huysse JL, Prohaska N, Miller C, et al. Adolescent eating disorder treatment outcomes of an in-person partial hospital program versus a virtual intensive outpatient program. *Int J Eat Disord*. 2023;56(1):192-202. <u>PubMed</u>
- Costa D, Charvin I, Da Fonseca D, Bat-Pitault F. Day hospital program for anorexia nervosa in children and adolescents: Assessment, management and specific focus on early onset anorexia nervosa. *Encephale*. 2022;14():14.
- Curzio O, Billeci L, Belmonti V, et al. Horticultural Therapy May Reduce Psychological and Physiological Stress in Adolescents with Anorexia Nervosa: A Pilot Study. *Nutrients*. 2022;14(24):07.
- Liu J, Rockwell RE, Kaye WH, Wierenga CE, Brown TA. Family functioning and eating disorders treatment in a partial hospitalization program in adolescent females with eating disorders. *Int J Eat Disord*. 2022;55(6):826-831. PubMed



- Nicolaou P, Merwin RM, Karekla M. Acceptability and feasibility of a gamified digital eating disorder early-intervention program (AcceptME) based on Acceptance and Commitment Therapy (ACT. *Journal of Contextual Behavioral Science*. 2022;25():26-34.
- Pauli D, Flutsch N, Hilti N, et al. Home treatment as an add-on to family-based treatment in adolescents with anorexia nervosa: A pilot study. *European Eating Disorders Review*. 2022;30(2):168-177. PubMed
- Perret H, Wolff V, Lamourette M, Decker D, Ligier F, Kabuth B. Evaluation of a cognitive remediation group within a pedopsychiatry service for patients suffering anorexia nervosa: A pilot study. *Neuropsychiatr Enfance Adolesc*. 2022;70(2)():75-81.
- Pruccoli J, La Tempa A, Francia V, et al. Anorexia nervosa among first- and second-generation immigrant children and adolescents in Italy: treatment and clinical outcomes. *Riv Psichiatr.* 2022;57(2):80-87. PubMed
- Wade T, Byrne S, Fursland A, et al. Is guided self-help family-based treatment for parents of adolescents with anorexia nervosa on treatment waitlists feasible? A pilot trial. Int J Eat Disord. 2022;55(6):832-837. PubMed
- Van Huysse JL, Lock J, Le Grange D, Rienecke RD. Weight gain and parental self-efficacy in a family-based partial hospitalization program. *Journal of Eating Disorders*. 2022;10(1):116. <u>PubMed</u>
- Bentz M, Pedersen SH, Moslet U. An evaluation of family-based treatment for restrictive-type eating disorders, delivered as standard care in a public mental health service. *Journal of Eating Disorders*. 2021;9(1):141. PubMed
- Chew CSE, Kelly S, Tay EE, et al. Implementation of family-based treatment for Asian adolescents with anorexia nervosa: A consecutive cohort examination of outcomes. *Int J Eat Disord*. 2021;54(1):107-116. PubMed
- Flanagan K. Expressed emotion and early treatment outcomes in adolescents with anorexia nervosa. Dissertation Abstracts International: Section B: The Sciences and Engineering. 2021;82(9-B):No Pagination Specified.
- Garber AK, Cheng J, Accurso EC, et al. Short-term Outcomes of the Study of Refeeding to Optimize Inpatient Gains for Patients With Anorexia Nervosa: A Multicenter Randomized Clinical Trial. JAMA Pediatr. 2021;175(1):19-27. PubMed
- Golden NH, Cheng J, Kapphahn CJ, et al. Higher-Calorie Refeeding in Anorexia Nervosa: 1-Year Outcomes From a Randomized Controlled Trial. *Pediatrics*. 2021;147(4):04.
- Knatz Peck S, Towne T, Wierenga CE, et al. Temperament-based treatment for young adults with eating disorders: acceptability and initial efficacy of an intensive, multi-family, parent-involved treatment. *Journal of Eating Disorders*. 2021;9(1):110. PubMed
- Lebow J, Mattke A, Narr C, et al. Can adolescents with eating disorders be treated in primary care? A retrospective clinical cohort study. *Journal of Eating Disorders*. 2021;9(1):55. PubMed
- Lebow J, O'Brien JRG, Mattke A, et al. A primary care modification of family-based treatment for adolescent restrictive eating disorders. *Eat*. 2021;29(4):376-389. PubMed
- Litmanovich-Cohen L, Yaroslavsky A, Halevy-Yosef LR, Shilton T, Enoch-Levy A, Stein D. Post-hospitalization Daycare Treatment for Adolescents With Eating Disorders. *Front Psychiatr.* 2021;12():648842.
- Lock J, Couturier J, Matheson BE, et al. Feasibility of conducting a randomized controlled trial comparing family-based treatment via videoconferencing and online guided self-help family-based treatment for adolescent anorexia nervosa. *Int J Eat Disord*. 2021;54(11):1998-2008. PubMed
- Mang L, Garghan A, Grant J, Lacey H, Matthews R. An evaluation of efficacy and acceptability of a novel manualised JuniorLEAP group programme for compulsive exercise, for children and adolescents with anorexia nervosa, within an inpatient setting. *Eat Weight Disord*. 2021;26(2):591-597. PubMed
- Meneguzzo P, Tenconi E, Todisco P, Favaro A. Cognitive remediation therapy for anorexia nervosa as a rolling group intervention: Data from a longitudinal study in an eating disorders specialized inpatient unit. *European Eating Disorders Review*. 2021;29(5):770-782. <u>PubMed</u>
- Rosello R, Gledhill J, Yi I, et al. Early intervention in child and adolescent eating disorders: The role of a parenting group. *European Eating Disorders Review*. 2021;29(3):519-526. <u>PubMed</u>
- Stewart CS, Baudinet J, Hall R, et al. Multi-family therapy for bulimia nervosa in adolescence: a pilot study in a community eating disorder service. *Eat.* 2021;29(4):351-367. PubMed



- Tenconi E, Collantoni E, Meregalli V, et al. Clinical and Cognitive Functioning Changes After Partial Hospitalization in Patients With Anorexia Nervosa. Front Psychiatry. 2021;12 (no pagination)():. PubMed
- Wang C, Xiao R. Music and art therapy combined with cognitive behavioral therapy to treat adolescent anorexia patients. Am J Transl Res. 2021;13(6)():6534-6542.
- Zanna V, Cinelli G, Criscuolo M, et al. Improvements on Clinical Status of Adolescents With Anorexia Nervosa in Inpatient and Day Hospital Treatment: A Retrospective Pilot Study. *Front Psychiatr.* 2021;12():653482.
- Brown TA, Murray SB, Anderson LK, Kaye WH. Early predictors of treatment outcome in a partial hospital program for adolescent anorexia nervosa. *Int J Eat Disord*. 2020;53(9):1550-1555. <u>PubMed</u>
- Dalle Grave R, Conti M, Calugi S. Effectiveness of intensive cognitive behavioral therapy in adolescents and adults with anorexia nervosa. Int J Eat Disord. 2020;53(9):1428-1438. PubMed
- Kern L, Morvan Y, Mattar L, et al. Development and evaluation of an adapted physical activity program in anorexia nervosa inpatients: A pilot study. *European Eating Disorders Review*. 2020;28(6):687-700. <u>PubMed</u>
- Loeb KL, Weissman RS, Marcus S, et al. Family-Based Treatment for Anorexia Nervosa Symptoms in High-Risk Youth: a Partially-Randomized Preference-Design Study. *Front Psychiatry*. 2020;10():. <u>PubMed</u>
- Martinez-Sanchez SM, Martinez-Garcia C, Martinez-Garcia TE, Munguia-Izquierdo D. Psychopathology, Body Image and Quality of Life in Female Children and Adolescents With Anorexia Nervosa: A Pilot Study on the Acceptability of a Pilates Program. *Front Psychiatr.* 2020;11():503274.
- Martinez-Sanchez SM, Martinez-Garcia TE, Bueno-Antequera J, Munguia-Izquierdo D. Feasibility and effect of a Pilates program on the clinical, physical and sleep parameters of adolescents with anorexia nervosa. *Complement Ther Clin Pract.* 2020;39():101161.
- Martinez-Sanchez SM, Martinez-Garcia TE, Munguia-Izquierdo D. Clinical, Psychopathological, Physical, and Sleep Evolution in Adolescents with Restrictive Anorexia Nervosa Participating in a Day Hospital Program. *Psychiatry Investig.* 2020;17(4):366-373. <u>PubMed</u>
- Matheson BE, Gorrell S, Bohon C, Agras WS, Le Grange D, Lock J. Investigating Early Response to Treatment in a Multi-Site Study for Adolescent Bulimia Nervosa. *Front Psychiatr.* 2020;11():92.
- Peterson CM, Van Diest AMK, Mara CA, Matthews A. Dialectical behavioral therapy skills group as an adjunct to family-based therapy in adolescents with restrictive eating disorders. *Eat.* 2020;28(1):67-79. <u>PubMed</u>
- Rosewall JK, Beavan A, Houlihan C, et al. Evaluation of Teen BodyWise: A pilot study of a body image group adapted for adolescent inpatients with anorexia nervosa. *Eat Weight Disord*. 2020;25(3):609-615. <u>PubMed</u>
- Serrano-Troncoso E, Fabrega-Ribera M, Coll-Pla N, et al. Alternatives to inpatient treatment in adolescents with anorexia nervosa: Effectiveness and characteristics of a new intensive model of day patient treatment. *Actas Esp Psiquiatr*. 2020;48(1):19-27. PubMed
- Skarbo T, Balmbra SM. Establishment of a multifamily therapy (MFT) service for young adults with a severe eating disorder experience from 11 MFT groups, and from designing and implementing the model. *Journal of Eating Disorders*. 2020;8():9.
- Thompson H, Hurst K, Green H, Watkins J, Collings N, Read S. Implementing family based treatment in a child and youth eating disorder program: impact on admissions. *Int J Adolesc Med Health*. 2020;32(6):19. PubMed
- Wakayama LNL. Preliminary effectiveness, credibility, feasibility, and acceptability of counter attitudinal therapy among college women. *Dissertation Abstracts International: Section B: The Sciences and Engineering*. 2020;81(6-B):No Pagination Specified.
- Ziv A, Meisman AR, Altaye M, Nash JK, Mitan L, Gordon C. 49. Yoga as an Intervention to Promote Bone Health in Adolescents With Restrictive Eating Disorders. J Adolesc Health. 2020;Vol.66(2):S26-S27p.
- Halvorsen I, Ro O. User satisfaction with family-based inpatient treatment for adolescent anorexia nervosa: retrospective views of patients and parents. *Journal of Eating Disorders*. 2019;7():12.
- Hughes EK, Sawyer SM, Accurso EC, Singh S, Le Grange D. Predictors of early response in conjoint and separated models of familybased treatment for adolescent anorexia nervosa. *European Eating Disorders Review*. 2019;27(3):283-294. <u>PubMed</u>

- Kucharska K, Kulakowska D, Starzomska M, Rybakowski F, Biernacka K. The improvement in neurocognitive functioning in anorexia nervosa adolescents throughout the integrative model of psychotherapy including cognitive remediation therapy. *BMC Psychiatry*. 2019;19(1):15. <u>PubMed</u>
- Makhzoumi SH, Schreyer CC, Hansen JL, Laddaran LA, Redgrave GW, Guarda AS. Hospital course of underweight youth with ARFID treated with a meal-based behavioral protocol in an inpatient-partial hospitalization program for eating disorders. *Int J Eat Disord*. 2019;52(4):428-434. PubMed
- Neumayr C, Voderholzer U, Tregarthen J, Schlegl S. Improving aftercare with technology for anorexia nervosa after intensive inpatient treatment: A pilot randomized controlled trial with a therapist-guided smartphone app. *Int J Eat Disord*. 2019;52(10):1191-1201. PubMed
- Pennell A, Webb C, Agar P, Federici A, Couturier J. Implementation of Dialectical Behavior Therapy in a Day Hospital Setting for Adolescents with Eating Disorders. *Journal of the Canadian Academy of Child & Adolescent Psychiatry = Journal de lAcademie* canadienne de psychiatrie de lenfant et de ladolescent. 2019;28(1):21-29.
- Rienecke RD. Treatment dropout in a family-based partial hospitalization program for eating disorders. *Eat Weight Disord*. 2019;24(1):163-168. PubMed
- Spettigue W, Norris ML, Douziech I, et al. Feasibility of Implementing a Family-Based Inpatient Program for Adolescents With Anorexia Nervosa: A Retrospective Cohort Study. *Front Psychiatr.* 2019;10():887.
- Berona J, Richmond R, Rienecke RD. Heterogeneous weight restoration trajectories during partial hospitalization treatment for anorexia nervosa. *Int J Eat Disord*. 2018;51(8):914-920. <u>PubMed</u>
- Chiumiento M. The use of three group therapy interventions for parents in an intensive outpatient program for adolescents with eating disorders. *Dissertation Abstracts International: Section B: The Sciences and Engineering*. 2018;78(7-B(E)):No Pagination Specified.
- Dimitropoulos G, Landers AL, Freeman V, Novick J, Garber A, Le Grange D. Open trial of family-based treatment of anorexia nervosa for transition age youth. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*. 2018;27(1)():50-61.
- Ganci M, Pradel M, Hughes EK. Feasibility of a parent education and skills workshop for improving response to family-based treatment of adolescent anorexia nervosa. *Int J Eat Disord*. 2018;51(4):358-362. PubMed
- Rienecke RD, Richmond RL. Three-month follow-up in a family-based partial hospitalization program. *Eat.* 2018;26(3):278-289. PubMed
- Depestele L, Claes L, Dierckx E, Colman R, Schoevaerts K, Lemmens GMD. An Adjunctive Multi-family Group Intervention with or without Patient Participation during an Inpatient Treatment for Adolescents with an Eating Disorder: A Pilot Study. *European Eating Disorders Review*. 2017;25(6):570-578. <u>PubMed</u>
- Herbrich L, van Noort B, Pfeiffer E, Lehmkuhl U, Winter S, Kappel V. Follow-up Assessment of Cognitive Remediation Therapy in Adolescent Anorexia Nervosa: A Pilot Study. *European Eating Disorders Review*. 2017;25(2):104-113. PubMed
- Herscovici CR, Kovalskys I, Orellana L. An Exploratory Evaluation of the Family Meal Intervention for Adolescent Anorexia Nervosa. *Fam Process*. 2017;56(2):364-375. <u>PubMed</u>
- Hodsoll J, Rhind C, Micali N, et al. A Pilot, Multicentre Pragmatic Randomised Trial to Explore the Impact of Carer Skills Training on Carer and Patient Behaviours: Testing the Cognitive Interpersonal Model in Adolescent Anorexia Nervosa. *European Eating Disorders Review*. 2017;25(6):551-561. <u>PubMed</u>
- Kapphahn CJ, Graham DA, Woods ER, et al. Effect of Hospitalization on Percent Median Body Mass Index at One Year, in Underweight Youth With Restrictive Eating Disorders. J Adolesc Health. 2017;61(3):310-316. PubMed
- Ornstein RM, Essayli JH, Nicely TA, Masciulli E, Lane-Loney S. Treatment of avoidant/restrictive food intake disorder in a cohort of young patients in a partial hospitalization program for eating disorders. *Int J Eat Disord*. 2017;50(9):1067-1074. <u>PubMed</u>
- Salaminiou E, Campbell M, Simic M, Kuipersd E, Eisler I. Intensive multi-family therapy for adolescent anorexia nervosa: An open study of 30 families. *J Fam Ther*. 2017;39(4):498-513.
- Goldstein M, Murray SB, Griffiths S, et al. The effectiveness of family-based treatment for full and partial adolescent anorexia nervosa in an independent private practice setting: Clinical outcomes. *Int J Eat Disord*. 2016;49(11):1023-1026. <u>PubMed</u>



- Lock J, Agras WS, Bryson SW, et al. Does family-based treatment reduce the need for hospitalization in adolescent anorexia nervosa?. Int J Eat Disord. 2016;49(9):891-4. PubMed
- Twohig MP, Bluett EJ, Cullum JL, et al. Effectiveness and clinical response rates of a residential eating disorders facility. *Eat*. 2016;24(3):224-39. PubMed
- van Noort BM, Kraus MK, Pfeiffer E, Lehmkuhl U, Kappel V. Neuropsychological and Behavioural Short-Term Effects of Cognitive Remediation Therapy in Adolescent Anorexia Nervosa: A Pilot Study. *European Eating Disorders Review*. 2016;24(1):69-74. <u>PubMed</u>
- Gelin Z, Fuso S, Hendrick S, Cook-Darzens S, Simon Y. The effects of a multiple family therapy on adolescents with eating disorders: an outcome study. *Fam Process*. 2015;54(1):160-72. <u>PubMed</u>
- Green J, Melvin GA, Newman L, Jones M, Taffe J, Gordon M. Day program for young people with anorexia nervosa. *Australasian Psychiatry*. 2015;23(3):249-53. <u>PubMed</u>
- Johnston JA, O'Gara JS, Koman SL, Baker CW, Anderson DA. A pilot study of maudsley family therapy with group dialectical behavior therapy skills training in an intensive outpatient program for adolescent eating disorders. *J Clin Psychol*. 2015;71(6):527-43. PubMed
- Murray SB, Anderson LK, Cusack A, et al. Integrating Family-Based Treatment and Dialectical Behavior Therapy for Adolescent Bulimia Nervosa: Preliminary Outcomes of an Open Pilot Trial. *Eat.* 2015;23(4):336-44. <u>PubMed</u>
- Timko CA, Zucker NL, Herbert JD, Rodriguez D, Merwin RM. An open trial of Acceptance-based Separated Family Treatment (ASFT) for adolescents with anorexia nervosa. *Behav Res Ther.* 2015;69():63-74.
- Agras WS, Lock J, Brandt H, et al. Comparison of 2 family therapies for adolescent anorexia nervosa: a randomized parallel trial. JAMA Psychiatry. 2014;71(11):1279-86. PubMed
- Gabel K, Pinhas L, Eisler I, Katzman D, Heinmaa M. The effect of multiple family therapy on weight gain in adolescents with anorexia nervosa: pilot data. *Journal of the Canadian Academy of Child & Adolescent Psychiatry = Journal de lAcademie canadienne de psychiatrie de lenfant et de ladolescent*. 2014;23(3):196-9.
- Asch M, Esteves J, De Hautecloque D, et al. [Cognitive remediation therapy for children and adolescents with anorexia nervosa in France: an exploratory study]. *Encephale*. 2014;40(3):240-6. <u>PubMed</u>
- Dalle Grave R, Calugi S, El Ghoch M, Conti M, Fairburn CG. Inpatient cognitive behavior therapy for adolescents with anorexia nervosa: immediate and longer-term effects. *Front Psychiatr*. 2014;5():14.
- Henderson K, Buchholz A, Obeid N, et al. A family-based eating disorder day treatment program for youth: examining the clinical and statistical significance of short-term treatment outcomes. *Eat*. 2014;22(1):1-18. <u>PubMed</u>
- Herpertz-Dahlmann B, Schwarte R, Krei M, et al. Day-patient treatment after short inpatient care versus continued inpatient treatment in adolescents with anorexia nervosa (ANDI): a multicentre, randomised, open-label, non-inferiority trial. *Lancet*. 2014;383(9924):1222-9. PubMed
- Neubauer K, Weigel A, Daubmann A, et al. Paths to first treatment and duration of untreated illness in anorexia nervosa: are there differences according to age of onset?. *European Eating Disorders Review*. 2014;22(4):292-8. PubMed
- Girz L, Robinson AL, Foroughe M, Jasper K, Boachie A. Adapting family-based therapy to a day hospital programme for adolescents with eating disorders: Preliminary outcomes and trajectories of change. *J Fam Ther.* 2013;35(Suppl 1):102-120.
- Dahlgren CL, Lask B, Landro NI, Ro O. Neuropsychological functioning in adolescents with anorexia nervosa before and after cognitive remediation therapy: a feasibility trial. *Int J Eat Disord*. 2013;46(6):576-81. PubMed
- Garcia-Garcia E, Rocha-Velis I, Vazquez-Velazquez V, Kaufer-Horwitz M, Reynoso R, Mendez JP. Experience of an eating disorders outpatient program in an internal medicine hospital. *Eat Weight Disord*. 2013;18(4):429-35. PubMed
- Hubert T, Pioggiosi P, Huas C, et al. Drop-out from adolescent and young adult inpatient treatment for anorexia nervosa. *Psychiatry Res.* 2013;209(3):632-7. <u>PubMed</u>



- Naab S, Schlegl S, Korte A, et al. Effectiveness of a multimodal inpatient treatment for adolescents with anorexia nervosa in comparison with adults: an analysis of a specialized inpatient setting: treatment of adolescent and adult anorexics. *Eat Weight Disord*. 2013;18(2):167-73. PubMed
- Wagner G, Wagner G, Penelo E, et al. Is technology assisted guided self-help successful in treating female adolescents with bulimia nervosa?. *Neuropsychiatr.* 2013;27(2):66-73. <u>PubMed</u>
- Jones M, Volker U, Lock J, Taylor CB, Jacobi C. Family-based early intervention for anorexia nervosa. *European Eating Disorders Review*. 2012;20(3):e137-43. PubMed
- Onnis L, Barbara E, Bernardini M, et al. Family relations and eating disorders. The effectiveness of an integrated approach in the treatment of anorexia and bulimia in teenagers: Results of a case-control systemic research. *Eating and Weight Disorders*. 2012;17(1):e36-e48. PubMed
- Ornstein RM, Lane-Loney SE, Hollenbeak CS. Clinical outcomes of a novel, family-centered partial hospitalization program for young patients with eating disorders. *Eat Weight Disord*. 2012;17(3):e170-7. PubMed
- Goldstein M, Peters L, Baillie A, McVeagh P, Minshall G, Fitzjames D. The effectiveness of a day program for the treatment of adolescent anorexia nervosa. *Int J Eat Disord*. 2011;44(1):29-38. PubMed
- Loeb KL, Craigen KE, Goldstein MM, Lock J, Le Grange D. Early treatment for eating disorders. *Eating disorders in children and adolescents: A clinical handbook*. 2011;():337-361.
- Wood L, Al-Khairulla H, Lask B. Group cognitive remediation therapy for adolescents with anorexia nervosa. *Clin Child Psychol Psychiatry*. 2011;16(2):225-231. <u>PubMed</u>
- del Valle MF, Perez M, Santana-Sosa E, et al. Does resistance training improve the functional capacity and well being of very young anorexic patients? A randomized controlled trial. *J Adolesc Health*. 2010;46(4):352-8. <u>PubMed</u>
- Bean P, Louks H, Kay B, Cornella-Carlson T, Weltzin T. Clinical observations of the impact of Maudsley therapy in improving eating disorder symptoms, weight, and depression in adolescents receiving treatment for anorexia nervosa. *J Groups Addict Recover*. 2010;5(1):70-82.
- Carei T, Fyfe-Johnson AL, Breuner CC, Brown MA. Randomized controlled clinical trial of yoga in the treatment of eating disorders. J Adolesc Health. 2010;46(4):346-351. PubMed
- Couturier J, Isserlin L, Lock J. Family-based treatment for adolescents with anorexia nervosa: a dissemination study. *Eat*. 2010;18(3):199-209. PubMed
- Gowers SG, Clark AF, Roberts C, et al. A randomised controlled multicentre trial of treatments for adolescent anorexia nervosa including assessment of cost-effectiveness and patient acceptability the TOuCAN trial. *Health Technol Assess*. 2010;14(15):1-98. <u>PubMed</u>
- Wildes JE, Marcus MD, Kalarchian MA, Levine MD, Houck PR, Cheng Y. Self-reported binge eating in severe pediatric obesity: impact on weight change in a randomized controlled trial of family-based treatment. *Int J Obes*. 2010;34(7):1143-8. <u>PubMed</u>
- Le GD, Doyle P, Crosby RD, Chen E. Early response to treatment in adolescent bulimia nervosa. *World psychiatry*. 2009;Vol.8(Suppl 1):35p.
- Paulson-Karlsson G, Engstrom I, Nevonen L. A pilot study of a family-based treatment for adolescent anorexia nervosa: 18- and 36-month follow-ups. *Eat*. 2009;17(1):72-88. PubMed
- Pretorius N, Arcelus J, Beecham J, et al. Cognitive-behavioural therapy for adolescents with bulimic symptomatology: the acceptability and effectiveness of internet-based delivery. *Behav Res Ther.* 2009;47(9):729-36. PubMed
- Prestano C, Lo Coco G, Gullo S, Lo Verso G. Group analytic therapy for eating disorders: preliminary results in a single-group study. *European Eating Disorders Review*. 2008;16(4):302-10. <u>PubMed</u>



Irrelevant Outcome (n = 2)

- Austin A, Flynn M, Richards KL, et al. Early weight gain trajectories in first episode anorexia: predictors of outcome for emerging adults in outpatient treatment. *Journal of Eating Disorders*. 2021;9(1):112. PubMed
- Austin A, Potterton R, Flynn M, et al. Exploring the use of individualised patient reported outcome measures in eating disorders. European Eating Disorders Review. 2021;29(6)():E19.

Other (irrelevant study design, full text not available) (n = 16)

- Hyam L, Richards KL, Allen KL, Schmidt U. The impact of the COVID-19 pandemic on referral numbers, diagnostic mix, and symptom severity in Eating Disorder Early Intervention Services in England. *Int J Eat Disord*. 2023;56(1):269-275. <u>PubMed</u>
- Salvatore L, Dancyger I, Shadianloo S, Fornari V. Caring for Transgender Youth with Eating Disorders in a Day Treatment Program. Adolesc Psychiatry. 2022;12(3)():196-206.
- Clark RR. Using problem-solving teleconsultation with parents to treat avoidant/restrictive food intake disorder in pediatric populations. Dissertation Abstracts International: Section B: The Sciences and Engineering. 2021;82(9-B):No Pagination Specified.
- Golden NH, Cheng J, Kapphahn C, et al. 14. One-Year Outcomes From a Multi-Center Randomized Controlled Trial (RCT) of Refeeding in Anorexia Nervosa: the Study of Refeeding to Optimize Inpatient Gains (STRONG). J Adolesc Health. 2021;Vol.68(2):S8p.
- Potterton R, Austin A, Flynn M, et al. "I'm truly free from my eating disorder": Emerging adults' experiences of FREED, an early intervention service model and care pathway for eating disorders. *Journal of Eating Disorders*. 2021;9(1):3. PubMed
- Schmidt U, Glennon D. FREED: Early intervention for eating disorders: Why, what and how?. *European Eating Disorders Review*. 2021;29(6)():E1.
- Allen KL, Mountford V, Brown A, et al. First episode rapid early intervention for eating disorders (FREED): From research to routine clinical practice. *Early Interv Psychiatry*. 2020;14(5):625-630. PubMed
- Kim S. The efficacy of family-based treatment for adolescents with eating disorders. *Dissertation Abstracts International: Section B: The Sciences and Engineering.* 2019;80(6-B(E)):No Pagination Specified.
- Cowdrey FA, Davis J. Response to enhanced cognitive behavioural therapy in an adolescent with anorexia nervosa. *Behav Cogn Psychother*. 2016;44(6):717-722. <u>PubMed</u>
- Godart N, Radon L, Duclos J, et al. Quantitative evaluation of the impact of family therapy: a randomized controlled trial comparison of adjunctive family therapy and treatment as usual following inpatient treatment for adolescent anorexia nervosa, a 13 years follow-up months outcome. *Eur Child Adolesc Psychiatry*. 2015;Vol.24(1):S112p.
- Herpertz-Dahlmann B. Randomized controlled non-inferiority trial of day patient treatment in comparison to inpatient treatment among adolescent patients with anorexia nervosa. Eur Child Adolesc Psychiatry. 2013;Vol.22(2):S96p.
- Foroughe MF. Examining family-based treatment for adolescents with restricting eating disorders. *Dissertation Abstracts* International: Section B: The Sciences and Engineering. 2012;73(1-B):614.
- Nicholls DE, Yi I. Early intervention in eating disorders: a parent group approach. Early Interv Psychiatry. 2012;6(4):357-67. PubMed
- Treasure J, Russell G. The case for early intervention in anorexia nervosa: theoretical exploration of maintaining factors. *Br J Psychiatry*. 2011;199(1):5-7. <u>PubMed</u>
- Evans GS. Effects of a 10-week strength training intervention among community-dwelling females with eating disorders. *Dissertation Abstracts International: Section B: The Sciences and Engineering*. 2008;68(9-B):5894.
- Gilbert G. Inpatient treatment equals outpatient treatment for anorexia. J Natl Med Assoc. 2008;100(7)():869-870.



References

- 1. Richards KL, Hyam L, Allen KL, et al. National roll-out of early intervention for eating disorders: process and clinical outcomes from first episode rapid early intervention for eating disorders. *Early Interv Psychiatry*. 2023;17(2):202-211. <u>PubMed</u>
- 2. Austin A, Flynn M, Shearer J, et al. The First Episode Rapid Early Intervention for Eating Disorders upscaled study: clinical outcomes. *Early Interv Psychiatry*. 2022;16(1):97-105. <u>PubMed</u>
- 3. Radunz M, Pritchard L, Steen E, Williamson P, Wade TD. Evaluating evidence-based interventions in low socio-economic-status populations. *Int J Eat Disord*. 2021;54(10):1887-1895. <u>PubMed</u>
- 4. Richards KL, Flynn M, Austin A, et al. Assessing implementation fidelity in the First Episode Rapid Early Intervention for Eating Disorders service model. *BJPsych Open*. 2021;7(3):e98. <u>PubMed</u>
- 5. Flynn M, Austin A, Lang K, et al. Assessing the impact of First Episode Rapid Early Intervention for Eating Disorders on duration of untreated eating disorder: a multi-centre quasi-experimental study. *Eur Eat Disord Rev.* 2021;29(3):458-471. <u>PubMed</u>
- 6. Fukutomi A, Austin A, McClelland J, et al. First Episode Rapid Early Intervention for Eating Disorders: a two-year follow-up. *Early* Interv Psychiatry. 2020;14(1):137-141. PubMed
- 7. McClelland J, Hodsoll J, Brown A, et al. A pilot evaluation of a novel First Episode and Rapid Early Intervention service for Eating Disorders (FREED). *Eur Eat Disord Rev.* 2018;26(2):129-140. <u>PubMed</u>
- 8. Brown A, McClelland J, Boysen E, Mountford V, Glennon D, Schmidt U. The FREED Project (First Episode and Rapid Early Intervention in Eating Disorders): service model, feasibility and acceptability. *Early Interv Psychiatry*. 2018;12(2):250-257. <u>PubMed</u>
- 9. Godart N, Dorard G, Duclos J, et al. Long-term follow-up of a randomized controlled trial comparing systemic family therapy (FT-S) added to treatment as usual (TAU) with TAU alone in adolescents with anorexia nervosa. *J Child Psychol Psychiatry*. 2022;63(11):1368-1380. PubMed
- Herpertz-Dahlmann B, Borzikowsky C, Altdorf S, Heider K, Dempfle A, Dahmen B. 'Therapists in action': home treatment in adolescent anorexia nervosa: a stepped care approach to shorten inpatient treatment. *Eur Eat Disord Rev.* 2021;29(3):427-442. <u>PubMed</u>
- 11. Coelho JS, Beach B, O'Brien K, Marshall S, Lam P-Y. Effectiveness of family-based treatment for pediatric eating disorders in a tertiary care setting. *Clin Pract Pediatr Psychol.* 2019;7(2):105-115.
- 12. Hurst K, Zimmer-Gembeck M. Family-based treatment with cognitive behavioural therapy for anorexia. *Clin Psychologist*. 2019;23(1):61-70.
- 13. Rosling A, Salonen Ros H, Swenne I. One-year outcome and incidence of anorexia nervosa and restrictive eating disorders among adolescent girls treated as out-patients in a family-based setting. *Ups J Med Sci.* 2016;121(1):50-59. <u>PubMed</u>
- 14. Godart N, Berthoz S, Curt F, et al. A randomized controlled trial of adjunctive family therapy and treatment as usual following inpatient treatment for anorexia nervosa adolescents. *PLoS ONE*. 2012;7(1):e28249. <u>PubMed</u>
- 15. Child Outcomes Research Consortium. Eating Disorder Examination Questionnaire (EDE-Q). [date unknown]; <u>https://www.corc.uk</u> .net/outcome-experience-measures/eating-disorder-examination-questionnaire-ede-q/. Accessed 2023 Aug 25.
- 16. Prnjak K, Mitchison D, Griffiths S, et al. Further development of the 12-item EDE-QS: identifying a cut-off for screening purposes. BMC Psychiatry. 2020;20(1):146. PubMed
- 17. Mitchell KS, Singh S, Hardin S, Thompson-Brenner H. The impact of comorbid posttraumatic stress disorder on eating disorder treatment outcomes: investigating the unified treatment model. *Int J Eat Disord*. 2021;54(7):1260-1269. <u>PubMed</u>
- 18. van Riel L, van den Berg E, Polak M, et al. Exploring effectiveness of CBT in obese patients with binge eating disorder: personality functioning is associated with clinically significant change. *BMC Psychiatry*. 2023;23(1):136. <u>PubMed</u>
- 19. Vaz AR, Conceicao E, Machado PP. Guided self-help CBT treatment for bulimic disorders: effectiveness and clinically significant change. *Psychother Res.* 2013;23(3):324-332. <u>PubMed</u>
- 20. Tatham M, Turner H, Mountford VA, Tritt A, Dyas R, Waller G. Development, psychometric properties and preliminary clinical validation of a brief, session-by-session measure of eating disorder cognitions and behaviors: the ED-15. Appendix 2 ED-15



questionnaire and scoring key. Int J Eat Disord. 2015;48(7):1005-1115. <u>https://c2coast.org.au/wp-content/uploads/20191211</u> _ED-15-Tool-and-Scoring-Key.pdf. Accessed 2023 Aug 25. <u>PubMed</u>

- Tatham M, Turner H, Mountford VA, Tritt A, Dyas R, Waller G. Development, psychometric properties and preliminary clinical validation of a brief, session-by-session measure of eating disorder cognitions and behaviors: the ED-15. *Int J Eat Disord*. 2015;48(7):1005-1015. <u>PubMed</u>
- Clausen L, Rosenvinge JH, Friborg O, Rokkedal K. Validating the Eating Disorder Inventory-3 (EDI-3): a comparison between 561 female eating disorders patients and 878 females from the general population. J Psychopathol Behav Assess. 2011;33(1):101-110. <u>PubMed</u>
- Garner DM, Olmstead MP, Polivy J. Development and validation of a multidimensional eating disorder inventory for anorexia nervosa and bulimia. Int J Eat Disord. 1983;2(2):15-34.
- 24. Canadian guidelines for body weight classification in adults. Ottawa (ON): Health Canada; 2003: <u>https://publications.gc.ca/</u> <u>collections/Collection/H49-179-2003E.pdf</u>. Accessed 2023 Sep 21.
- 25. Rodd C, Sharma AK. Recent trends in the prevalence of overweight and obesity among Canadian children. *CMAJ*. 2016;188(13):E313-E320. <u>PubMed</u>
- 26. Morgan HG, Hayward AE. Clinical assessment of anorexia nervosa. The Morgan-Russell outcome assessment schedule. *Br J Psychiatry*. 1988;152:367-371. PubMed
- 27. Evans C, Connell J, Barkham M, et al. Towards a standardised brief outcome measure: psychometric properties and utility of the CORE-OM. *Br J Psychiatry*. 2002;180:51-60. PubMed
- 28. NovoPsych. Clinical Outcomes in Routine Evaluation (CORE-OM). 2023; https://novopsych.com.au/assessments/outcome-om/. Accessed 2023 Sep 21.
- 29. Implementing routine outcome monitoring. London (GB): Child Outcomes Research Consortium (CORC); 2019: <u>https://www.corc</u> .uk.net/media/2311/perinatal-roms-manual-a4-final-print-december-2019.pdf. Accessed 2023 Sep 21.
- 30. NovoPsych. Clinical Outcomes in Routine Evaluation 10 (CORE-10). 2023: <u>https://novopsych.com.au/assessments/outcome-monitoring/clinical-outcomes-in-routine-evaluation-10-core-10/</u>. Accessed Aug 25, 2023.
- Barkham M, Margison F, Leach C, et al. Service profiling and outcomes benchmarking using the CORE-OM: toward practice-based evidence in the psychological therapies. Clinical Outcomes in Routine Evaluation-Outcome Measures. J Consult Clin Psychol. 2001;69(2):184-196. <u>PubMed</u>
- 32. NovoPsych. Clinical Impairment Assessment Questionnaire (CIA). 2023; <u>https://novopsych.com.au/assessments/diagnosis/</u> <u>clinical-impairment-assessment-questionnaire-cia/</u>. Accessed 2023 Aug 25.
- 33. Bohn K, Doll HA, Cooper Z, O'Connor M, Palmer RL, Fairburn CG. The measurement of impairment due to eating disorder psychopathology. *Behav Res Ther.* 2008;46(10):1105-1110. PubMed
- 34. NovoPsych. Depression Anxiety Stress Scales Short Form (DASS-21). 2023; <u>https://novopsych.com.au/assessments/</u> <u>depression/depression-anxiety-stress-scales-short-form-dass-21/</u>. Accessed 2023 Sep 21.
- 35. Antony MM, Bieling PJ, Cox BJ, Enns MW, Swinson RP. Psychometric properties of the 42-item and 21-item versions of the Depression Anxiety Stress Scales in clinical groups and a community sample. *Psychological Assessment*. 1998;10(2):176-181.
- 36. Cole JD, Kazarian SS. The level of expressed emotion scale: a new measure of expressed emotion. *J Clin Psychol.* 1988;44(3):392-397. PubMed
- 37. Nelis SM, Rae G, Liddell C. The level of expressed emotion scale: a useful measure of expressed emotion in adolescents? *J Adolesc.* 2011;34(2):311-318. PubMed
- Ashworth M, Shepherd M, Christey J, et al. A client-generated psychometric instrument: the development of 'PSYCHLOPS'. Counselling & Psychotherapy Research. 2004;4(2):27-31.
- The PSYCHLOPS Team. A questionnaire about you and how you are feeling. 2017; <u>http://www.psychlops.org.uk/sites/default/</u> <u>files/PSYCHLOPS,%20pre-therapy.pdf</u>. Accessed 2023 Sep 21.



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- Gomez R, Stavropoulos V, Zarate D, Palikara O. Symptom Checklist-90-revised: a structural examination in relation to family functioning. PLoS ONE. 2021;16(3):e0247902. <u>PubMed</u>
- 41. Vaurio R. Symptom Checklist-90-revised. Encyclopedia of Clinical Neuropsychology. New York (NY): Springer; 2011.
- 42. SCIRE. Symptom Checklist-90-Revised (SCL-90-R). 2022; <u>https://scireproject.com/outcome/symptom-checklist-90-revised-scl</u> -90-r/. Accessed 2023 Sep 21.
- Schmitz N, Hartkamp N, Franke GH. Assessing clinically significant change: application to the SCL-90-R. Psychol Rep. 2000;86(1):263-274. <u>PubMed</u>
- 44. Park K, Jaekal E, Yoon S, Lee SH, Choi KH. Diagnostic utility and psychometric properties of the Beck Depression Inventory-II among Korean adults. *Front Psychol.* 2019;10:2934. <u>PubMed</u>
- 45. Almeida S, Camacho M, Barahona-Corrêa JB, et al. Criterion and construct validity of the Beck Depression Inventory (BDI-II) to measure depression in patients with cancer: the contribution of somatic items. *Int J Clin Health Psychol.* 2023;23(2):100350. PubMed
- 46. Chaudron LH, Szilagyi PG, Tang W, et al. Accuracy of depression screening tools for identifying postpartum depression among urban mothers. *Pediatrics*. 2010;125(3):e609-617. <u>PubMed</u>
- 47. Flett GL, Hewitt PL, Besser A, et al. The Child–Adolescent Perfectionism Scale: development, psychometric properties, and associations with stress, distress, and psychiatric symptoms. *Journal of Psychoeducational Assessment*. 2016;34(7):634-652.
- 48. Mundt JC, Marks IM, Shear MK, Greist JH. The Work and Social Adjustment Scale: a simple measure of impairment in functioning. *Br J Psychiatry*. 2002;180:461-464. <u>PubMed</u>
- 49. Weissman MM, Bothwell S. Assessment of social adjustment by patient self-report. *Archives of General Psychiatry*. 1976;33(9):1111-1115. <u>PubMed</u>
- 50. Gameroff MJ, Wickramaratne P, Weissman MM. Testing the short and screener versions of the Social Adjustment Scale-Selfreport (SAS-SR). Int J Methods Psychiatr Res. 2012;21(1):52-65. PubMed
- 51. Berman AH, Liu B, Ullman S, Jadbäck I, Engström K. Children's quality of life based on the KIDSCREEN-27: child self-report, parent ratings and child-parent agreement in a Swedish random population sample. *PLoS ONE*. 2016;11(3):e0150545. <u>PubMed</u>
- KIDSCREEN. KIDSCREEN-27. [date unknown]; <u>https://www.kidscreen.org/english/questionnaires/kidscreen-27/</u>. Accessed 2023 Sep 21.



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