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Eating disorders are serious mental health conditions which commonly begin in adolescence. Multi-family therapy (MFT) is recommended for young people with anorexia, but to date the majority of research on the effectiveness of this intervention has been conducted in highly specialist eating disorder (ED) services. In England there is a national transformation programme which aims to develop specialist community ED services for children and young people. Across many regions community ED services are in the early stages of development, and the structure of these teams may vary. The current study aimed to explore whether MFT can be effectively implemented in a newly developed community ED service in the south-west of England. Following one pilot MFT group, focus groups were conducted with caregivers and MFT facilitators to qualitatively explore how they experienced MFT. Results showed that MFT is valued by both service-users and clinicians in community ED settings, but there are challenges associated with providing MFT in this context. Guidance for meeting these challenges is provided.

Implementing Multi-Family Therapy (MFT) within a community eating disorder

services for children and young people (CEDS-CYP)

Eating disorders (ED) are serious mental health difficulties with significant physical and psychological consequences (NHS England, 2015). EDs commonly begin in adolescence and can follow a chronic and disabling course into adulthood (Nagl et al., 2016). Offering evidence-based interventions to young people earlier in their illness results in better recovery rates, less risk of inpatient admission, and lower relapse rates (NHS England). Additionally, individuals receiving care from dedicated ED services have better outcomes and families are more satisfied with specialist care than with generic mental health services (House et al., 2012; Roots, Rowlands, & Gowers, 2009).

Developments to Eating Disorder Services for young people in the UK

In 2015, the National Health Service (NHS England) developed a transformation plan to improve ED services for young people. Services were restructured to create dedicated ED teams specifically for children and young people (referred to as 'Community Eating Disorder Services for Children and Young People, CEDS-CYP'; NHS England, 2015). Specialist community ED services for young people are becoming increasingly established in England, however many of these services are in early stages of development and their structure varies across the country (NHS England, 2015). Some regions have a dedicated ED service that sits independently from general child and adolescent health services, whilst in other regions community ED services sit within a generic child and adolescent mental health service. In some regions specialist ED teams are comprised of a network of clinicians across a larger region who specialise in child and adolescent mental health.

Regardless of which service they access, the National Institute of Clinical Excellence (NICE; the national provider of health and social care guidance in the UK) recommends evidence-based therapies that should be offered to young people with an ED. When treating

Anorexia Nervosa (AN), which is the focus of this study, NICE (2017) recommends that young people should be offered anorexia-nervosa-focused family therapy, delivered as single-family therapy (SFT) or a combination of single and multi-family therapy (MFT).

In the UK, the development of both SFT and MFT has been informed by clinical practice and research within a highly specialised ED service (South London and Maudsley; SLaM). This service has shaped these interventions through clinical experimentation within their service and helped to develop practitioner manuals for these interventions (Eisler, Simic, Blessitt, & Dodge, 2016). SFT is now embedded in ED treatment pathways across the UK, but MFT is a more recent development and is not yet routinely offered by all services.

Multi Family Therapy (MFT)

Both SFT and MFT are systemic outpatient interventions which view the family as an important resource for the adolescent to recover (Eisler, Le Grange & Lock, 2015). Both approaches encourage parents to initially take the lead in managing their child's eating and to move towards the child re-gaining control of their eating once it is deemed safe to do so (Dare & Eisler, 2000; Eisler, Le Grange & Lock, 2015). Both interventions draw on key systemic principles to identify and explore how AN influences patterns of behaviour and beliefs within a family and to create a shared narrative of the AN within this system. SFT and MFT interventions both: use narrative therapy techniques to 'externalise' the AN and explore the role it plays in the family (White & Epston, 1990); help family members to explore and identify how patterns of circularity within the family system contribute to the young person's difficulties; facilitate the development of any new or different patterns; encourage family members to share their perspectives and to develop a shared understanding of the AN; and address disruptions to typical life-cycle transitions that are common when a young person has an ED. SFT and MFT share similar methods and techniques to explore systemic issues and to generate systemic change. For example, both interventions include 'family meals' so patterns

during meal-times can be observed, use role-play to facilitate shared understanding of the AN, and use sculpt techniques to recognise the role of the AN within the family.

Whilst MFT and SFT share similar systemic principles and use similar techniques, MFT is delivered in a more intensive format. MFT consists of a four-day group followed by follow-up days over several months. MFT typically includes 5-7 families and aims to help families feel less isolated and stigmatised (Eisler et al., 2016). MFT emphasises that families should develop and build-on their own resources to overcome the difficulties they are facing (Eisler et al., 2016), and works from the premise that this is facilitated by being around other families with similar experiences. There is an idea that families form connections, become interested in helping each other, learn from one another and share suggestions, perspectives and ideas (Asen & Scholz, 2010). By bringing families together, it is thought individuals feel less 'defensive' and are better able to constructively reflect on their difficulties (Asen & Scholz, 2010). It is also thought that being around other families who have overcome similar dilemmas can generate a sense of hope and help individuals to feel less 'stuck'.

Whilst research into MFT is limited, some benefits of this intervention have been reported. Both carers and young people report that MFT is helpful (Scholz & Asen, 2001), and carers who have attended MFT report increased autonomy and confidence in supporting their child (Depestele, Claes & Lemmens, 2015; Engman-Bredvik, Carballeira Suarez, Levi, & Nilsson, 2016). MFT is more economical than inpatient interventions, and preferred by service-users (Scholz, Rix, Scholz, Gantchev, & Thömke, 2005). Young people who attend MFT have demonstrated decreases in ED symptomology (Hollesen, Clausen, & Rokkedal, 2013).

Most of this research demonstrating the efficacy of MFT has been conducted within highly specialised ED services (e.g. South London and Maudsley; SLaM). There is limited understanding of how MFT can be offered in the newly developed community ED services for young people, and particularly ones that are situated within or alongside generic mental health

services. It is important to better understand this, as community based ED services continue to be established and developed across the UK.

Local context - The current study

This study was conducted in the Bristol and South Gloucestershire (B&SG) region, in the South West of the UK. At the time of conducting this project the region was developing a dedicated community ED service for young people. This ED service is now comprised of a specialist ED 'hub' as well as a network of general mental health clinicians across the B&SG region who have an interest in EDs. As this community ED service was developed, the first MFT group for young people with AN was piloted in this region. This group was piloted from November 2015 to June 2016.

Aims

This project aimed to explore the experiences of carers who attended the pilot MFT group, and to explore whether MFT can be adapted effectively within a community ED setting. This evaluation drew on experiences of more established community ED services in the UK, to inform and improve how MFT might be incorporated into the newly developing community ED service in B&SG.

Method

Procedure

This study was approved by the University of Bath and received site-specific approval from research and development teams at each participating site.

The MFT Group

The MFT group comprised four intensive days and five follow-up sessions over seven months. The group included individuals accessing both inpatient and outpatient services, and all individuals were known to clinicians within the team. Clinicians assessed individual's suitability for MFT, taking into consideration their physical health and their ability to engage

in a group intervention. Individuals were not excluded from MFT on the basis of comorbid mental health difficulties or trauma. If these issues were relevant they would typically be considered within SFT rather than MFT.

Five families attended MFT, which was facilitated by two clinical psychologists and two family therapists. Two individuals from outpatient services and three adolescents from inpatient services attended. Three adolescents attended with their mother and father, one with her grandparent, and one alternately attended with her mother, father, and stepfather. All families received SFT alongside MFT.

All young people were female. Males were invited to attend this group but all declined. Eating disorders are often perceived as an illness affecting females, and males are commonly reluctant to access services. Young people who attended MFT had a mean age of 14.6 (range 14-16 years). Their mean weight for height percentage was 85% (range 82% to 89%), which is outside the range of a healthy weight for height and consistent with a diagnosis of AN.

All individuals who attended the MFT group were white British. However, this sample had diverse socio-economic backgrounds. Some families experienced significant social stressors (e.g., parental mental health difficulties, financial concerns and social care involvement), whilst others did not.

Study participants

MFT attendees. Convenience sampling was used to identify participants for this study. All MFT attendees were approached by the lead group facilitator, given written information about the study, and invited to take part in a focus group about the MFT group. Four carers from three of the families consented to take part. Young people chose not to participate in a focus group.

Clinicians. Two B&SG clinicians who facilitated the pilot MFT group (site 1) were given information about this study. These clinicians (family therapists) were not involved in

the development of this study. Both consented to take part in a semi-structured interview about their experiences of facilitating this intervention.

MFT clinicians from two other community ED services in the south-west of the UK (Site 2: Exeter, Site 3: Weston) were invited to take part in a semi-structured interview about MFT. Both of these specialist ED teams are situated within general mental health services and have already implemented MFT in their treatment pathways. It was hoped that understanding the experiences of offering MFT within more established community ED services could inform how B&SG offers MFT in future. Two clinicians from each site (clinical psychologists or family therapists) consented to take part.

Analytic Approach

All focus groups and interviews followed a semi-structured interview schedule. They were conducted by the main researcher, who was not involved in facilitating MFT and did not have any prior relationships with any participants. Focus groups/interviews were audio-recorded and transcribed. Due to limited researcher resources participants did not have the opportunity to review these transcripts.

Qualitative data was analysed using thematic analysis (Braun & Clarke, 2006). In line with recommendations for qualitative research the lead researcher familiarised themselves with the data by transcribing the data and reading each transcript several times (Nowell, Norris, White, & Moules, 2017). The researcher identified inductive codes within the data but was also aware of their pre-existing ideas about what might be valuable or challenging about offering MFT. A second researcher reviewed the codes and themes and identified an additional theme regarding wider-service challenges. Themes were fully defined and finalised at this point.

Results

Three themes were identified in relation to offering MFT in a community-based ED service for young people: the value of this intervention; the set-up and structure; and associated challenges (Figure V).

Figure V. Themes identified from focus-groups with therapists and carers.

Theme 1: The value of offering MFT in a specialist community ED service

Carers. Carers were positive about MFT. They frequently reported that it was helpful sharing experiences with others.

Carer C: "I found it very helpful, like everyone else says for meeting people going through the same situation but also I think some of the sessions were informative…some of them…made quite a big impact on me."

Young people. Carers and clinicians who facilitated the pilot B&SG group were concerned that young people did not engage with the group. Whilst carers primarily focused on the challenges associated with lack of young peoples' engagement, they also reflected that young people may have gained something from the experience of being present during the MFT group and being exposed to the discussions and activities that were facilitated.

Carer B: "maybe the young people are sort of joining in by not joining in, showing their opinions or not joining in, showing their difficulties...and at least they're kind of exposed to it all, even if they are passive"

Carer A: "I am going to change something that I said earlier, that X didn't get anything from it. I have just remembered that after sessions, on the way home, she would be really quite jolly and sort of positive about stuff because of what she had just been through. Whether it was trying to show to us that 'actually I can do this' or 'thank god that's over with'...in a way it was useful because she was then 'oh thank god let's try and eat something, try and think about food, try and talk about stuff' so maybe yes there was a positive effect, you know, afterwards"

Therapists from sites 2 and 3, who were increasingly experienced in facilitating the MFT group, reflected that despite initial reluctance to engage, they believed young people benefited from MFT.

Therapist site 3: "We've used goal-based outcomes so they've all had their own goal at the beginning and pretty much all of them have reached their goal whatever that might be...and we've had at least three or four who've come back and been willing to do graduate family [presentation] and really sold the group...and said, I didn't want to come but now I can see why and it's been great."

Theme 2: The set-up and structure of MFT in a specialist community ED service

The MFT manual provides a general programme outline. However, there is space for facilitators to adapt the intervention to best suit the needs of the specific group. Therapists and carers commented on aspects of the programme they felt were especially effective, and therapists spoke about the general approach of MFT. Therapists discussed options for how MFT could be most effectively set-up in community ED teams that are based within generic mental health services, given that the service as a whole is not dedicated to ED work.

Programme Content.

Flexibility of approach. The flexibility of the MFT programme allowed clinicians to selectively choose activities most appropriate for the group. They thought this enabled them to better engage young people by judging when they were ready for a particular aspect of the intervention. This was also recognised and valued by carers, who reported that they noticed therapists altered the content of the MFT programme to meet their needs.

Therapist site 3: "It's nice to have the outline of the different activities that there are to use, but then be able to kind of mould it around what's needed."

Therapist site 2: "If you've got a room full of young people who are really struggling it's about having that flexibility, because if they are not at a space for the activity that you thought they might be...how do you quickly regroup it to be something they can use?"

Carer C: The therapists seemed very responsive to the group. I think they tried hard to take on board what we said about what we wanted to do in sessions and they reordered things or changed sessions in response to what we were saying so that was really good.

Mix of emotive and less-emotive material. Therapists and carers emphasised the usefulness of having a mix of emotive and less-emotive activities within the programme.

Carer C: "[The group] was a good mix I think…when we had had some heavy sessions then some games were quite good to…lighten the atmosphere."

Specific activities. Carers identified several helpful activities within MFT, but a few were noted as being particularly powerful. They said that 'sculpt activities' (Heinl, 1987) were helpful for recognising how the AN organises the family, and role-playing the voice of anorexia helped them to understand their child's experiences.

Carer C: "We did some role play stuff at the beginning which I just hated the idea of…but when sort of forced into the spot it left a lasting impression actually -- it was very powerful."

MFT Structure.

Follow-up sessions. Therapists across all sites questioned how suitable an extensive follow-up period was for their client population. Despite this being a common concern raised by therapists, the carers did not speak about the follow-up period as feeling inappropriate or unsuitable for their needs. It would be useful to explore this further, to understand why the perspectives of therapists and carers may differ in relation to the follow-up sessions and how useful these are.

Therapist site 3: "Our experience is that after about two, maybe three [follow-up sessions], people start dropping out, it's just too much, it just doesn't quite fit, so I wonder [if] we may adapt that so that we do three follow-up days rather than trying to eke it out to six.

Sibling days. The MFT manual recommends a sibling day, and other services found this helpful. Therapists thought it might be helpful for different siblings for different reasons, depending on the family dynamics and relationships.

Therapist site 3: "Probably different families found it helpful for different reasons. Sometimes there were older siblings that could just be a support for the younger person, sort of like 'I'll help you get through it, bit of an ally' and other times it was helpful for them to understand a bit more about what was going on for their sibling."

The B&SG pilot group did not have enough sibling uptake to warrant a sibling day, and this is a notable limitation of this pilot. Because a sibling day was not offered as part of the pilot MFT group the carers did not discuss this within the focus group. They also did not discuss in the focus group how their wider families were impacted by the ED and whether or not they felt a sibling group would be helpful. Previous research suggests that input for siblings of young people with an ED is noticeably lacking (Honey & Halse 2007). Furthermore, research suggests that siblings of young people with an ED can be negatively impacted by this illness, and that their adjustment can be influenced by parental responses to the ED and parental communication about the ED (Honey & Halse, 2007). It is therefore essential to understand how MFT, regardless of the context in which it is delivered, can most effectively and usefully include siblings, and how services can promote engagement of siblings within this intervention.

Theme 3: The challenges of implementing MFT in a community ED team within a generic mental health service

Young people's engagement. The most commonly identified challenge of the B&SG MFT group was young people's reluctance to engage. Carers spoke a lot about this and raised this as the primary challenge of engaging in the MFT intervention. They discussed how the young people found it hard to participate in the group and to contribute to discussions. In particular, one carer spoke about her prior expectations and hopes for the MFT intervention, and spoke about how reluctance from the young people to engage meant that they were not able to gather the insight and understanding of their daughters difficulties in the way that they had hoped.

Carer A: "our daughter…she didn't want to be there, didn't want to do it, and at the worst of it we were sitting there thinking 'Why are we here?'"

Carer B: "when we were all together the therapists were trying very hard to engage the young people and..I think they were all very sort of hesitant weren't they…I guess we were all thinking 'come on, say something', sort of wishing that they would participate a bit more"

Carer C: "I was hoping that we would get a little bit more from the young people to help us understand and think about what they found helpful, but because they found it so difficult to express themselves it felt like there wasn't a huge amount of that"

Therapists from other services also acknowledged that young people's engagement could be problematic, but thought engagement generally increased over the course of the group. Providing space for young people to bond without facilitators was thought to promote engagement. This challenge may be endemic to MFT, regardless of the setting.

Therapist site 3: "I think it takes a while for young people to engage because actually they don't want to get better -- getting better means eating and they don't want to eat, they don't want to gain weight -- but, the feedback is that as time goes on they can see what's been useful".

Therapist site 2: "What we tended to find easier is to give them an activity and then come in and out of the room…and actually found that they did interact with each other or were all kind of doing stuff in silence … that kind of 'being around but not' seemed to work quite well for them."

Not having a rolling programme. Therapists highlighted a key difference between offering MFT in a community ED team within a generic mental health service, and offering it within a highly specialised ED service (e.g. SLaM). Community ED teams situated within generic mental health services were not able to offer a rolling programme of MFT. There were several difficulties associated with this.

Offering MFT appropriate to individual needs. Therapists reported that because MFT was offered infrequently, attendance was sometimes based on practical considerations such as availability, parental willingness, and physical wellness. There was less flexibility to consider

family circumstances or individuals stage of recovery and to offer MFT when it felt most helpful. There was a consensus all young people with ED could benefit from MFT, but no agreement as to when it might be most effective in regards to stage of recovery. Therapists agreed it is more important to consider an individuals' current needs in relation to the focus of their treatment.

Therapist site 2: "I was thinking [about] the family who had got quite stuck. I don't know if [MFT] would have worked for them in the beginning. I think that year of processing got them to the point where they were ready and could kind of say 'yes we need it'."

Therapist site 2: "It's a bit more complicated than 'are you at this stage or this stage'. It's about thinking about where are you at and what do you need…. In some ways it has to be people who the main focus of the work is about managing eating and understanding eating disorders".

Only one carer spoke about how their young person perceived themselves to relate to others within the group. This carer reported that their young person did not identify with the feelings or experiences that others were describing. This young person was experiencing ongoing mental health and social difficulties that influenced the presentation and experience of their ED. MFT focuses specifically on EDs, and it is possible that this was not an appropriate time for this young person to engage in this intervention as it did not address the difficulties that were presently most prominent and troubling to them.

Carer D: "she kept saying it wasn't the same for her, some of the feelings, you know, it wasn't the same for her, she was different"

Group composition. Not having a rolling-programme also inhibits selectivity in the mix of individuals who might comprise the group. Clinicians across all focus-groups consistently raised this as a challenge. MFT training proposes individuals at various stages of ED can be within one group but both therapists and carers had mixed views on this.

Therapist site 2: "I remember doing the training being really surprised when they talked about it being okay if someone's brand new and someone's quite recovered…that would be incredibly hard to manage. If you had someone really ill and really struggling and someone much further down the line I would be very concerned about the risks both ways."

Therapist site 3: "I think that mix is really helpful as well -- like for people who are really struggling to see actually you can come out the other side, you can get better. And also for those people to be able to recognise that they have come a long way and actually it's not as bad as it used to be"

Carer D: "For me to see (another young person) sat at a table eating was encouraging for me to think 'my X could do that soon'… it gave me hope that my X could reach that stage."

Facilitators' experience and confidence. Clinicians found facilitating MFT rewarding and thought it enhanced their practice. However, they identified practical, personal and professional challenges of implementing MFT, some of which may be reduced if they facilitated MFT regularly.

A key benefit of MFT is families can share ideas and learn from one another. However, one therapist within B&SG found it difficult to challenge ideas posed by families that might unwittingly maintain ED behaviours. This was not voiced by therapists who have delivered MFT regularly, and the B&SG therapists acknowledged over the course of the group they felt more confident in challenging 'unhelpful' ideas.

Therapist site 1: "I had some dilemmas about some of the solutions that were offered and whether we should say more…when people came up with sort of pro-anorexic solutions".

Clinicians discussed how it can feel to have ones' clinical skills and abilities exposed in front of multiple individuals. When facilitating MFT they often had to make quick decisions without discussing with co-therapists, and reported it felt like taking 'risks' in front of a big audience. Clinicians highlighted the importance of supervision to manage these issues.

Therapist site 1: "It's potentially exposing for us because we had to make some quite big interventions and decisions very quickly...if our interventions hadn't gone the right way then that would have been very difficult".

Therapist site 1: "For me that was invaluable to have a separate space with someone who could sort of take a meta-position, who was more experienced than us at running these groups and someone we all...knew and trusted".

Lastly, whilst the flexibility of MFT is a positive aspect of this intervention, therapists thought that to most effectively adapt the programme clinicians required knowledge and experience of MFT.

Therapist site 3: "another reason why I think it's really important to have a rolling programme to do regularly is so that all the people facilitating have a really good knowledge of the programme and what you are doing, what activities you could draw on. Because you do sometimes have to think 'okay well we need to change plan -- someone's become really distressed or that's going to hit too much about something that's happened in their life -- what can we do differently'?"

Practical Challenges.

Family availability. Therapists noted that attending MFT required families to arrange time-off work, childcare, and travel. A rolling programme might reduce these difficulties as families would have increased opportunities to attend. Carers emphasised practical challenges were worth overcoming in order to engage with an intervention that could potentially help their child.

Carer B: "You just have to accept that you have to take some time off or make some arrangement or whatever...and the level of importance in doing it is such that you should".

Service resources. Therapists noted professional commitments and staff resources impede the ability to offer a rolling programme. One therapist reflected this challenge is more likely to affect clinicians working in a team operating within a generic mental health service,

than in a specialist setting dedicated solely to ED treatment. Clinicians valued having dedicated time to commit to families.

Therapist site 2: "Four staff is a big commitment for what we offer…it takes a whacking great chunk of the family service out [of general practice], and that's over [and above] the families who aren't part of the group who need seeing and managing."

Therapist site 1: "It was like taking a week out of work essentially - we are talking about the practical implications of taking four days out of work…but it meant that we could just focus on MFT and MFT only..."

Discussion

This pilot study suggested that MFT can be implemented in a specialist community ED service for young people, and that service-users find it valuable in this setting. Caregivers were positive about MFT, expressing how helpful it was to share experiences with others. Young people's experiences were less understood, and there was some concern they did not engage with the intervention, perhaps because it challenges their ED. Later in recovery, when ED psychopathology has reduced, young people may be able to better reflect on the usefulness of MFT. There is some support for this idea, as following the conclusion of this project, one young person from the pilot group acted as a 'graduate' for MFT in another region and spoke positively of her experiences.

Despite recognising the value of implementing MFT in a community ED service, clinicians identified challenges associated with offering MFT in teams that sit within generic mental health services. Clinicians from the three community ED teams involved in this study all stated that they were not able to offer a rolling programme of MFT in this setting, primarily due to service resources and feasibility. They believed that not having a rolling-programme prevented MFT from being offered in the most appropriate, flexible and effective manner.

Clinicians believed infrequent MFT programming impacts opportunities for individuals to attend when it is most appropriate for their recovery and creates difficulties in comprising the most effective group compositions. There was particular concern about whether individuals at different stages in their illness should be included in a group. It would be helpful to understand young peoples' views on how the composition of group attendees might influence their experience of MFT and their recovery.

Clinicians also raised concerns that delivering MFT on an infrequent basis affected their confidence in facilitating this intervention. More experienced clinicians were thought to be more competent in adapting the intervention to suit group needs, again improving the effectiveness of this intervention. If teams do not have the capacity to provide a rolling programme, clinicians may not feel as skilled and competent in offering this intervention.

Limitations

The biggest limitation of this project is that young peoples' perspectives are missing. Young people did not want to participate in a focus group, and all declined a subsequent invitation to engage in an individual interview. As reflected in both clinicians and caregivers qualitative reports, all young people were reluctant to engage in the MFT group and treatment generally. This is not surprising, as much of the MFT content is challenging and incongruent with desires to lose weight. In eating disorder treatment it is commonly observed that behavioural change precedes cognitive change (Murphy, Straebler, Cooper, & Fairburn, 2010). It is possible that ongoing eating disordered cognitions may have prevented young people from feeling willing or able to engage in discussion about their treatment.

Additionally, as the first line treatment for ED in young people is family-based treatment, young people may feel that they have limited choice over whether or not they attend treatment. This may lead to a difficult dynamic within their system of care, in which the young person has little motivation or will to actually engage in treatment. If young people have a

difficult relationship with services they may be particularly unwilling to engage in additional research opportunities beyond their basic treatment package.

It was also identified that all males invited to attend the MFT group declined. It is a common issue that males are reluctant to seek help in relation to their eating difficulties, as this illness is typically perceived as a 'female problem' (Strother, Lemberg, Stanford & Turberville, 2012). This issue may be exacerbated when an intervention is in a group rather than an individual format. As a result, there is limited research relating to males and eating disorders, which is a limitation of this project and the wider literature more generally.

Finally, this project was a pilot study with a small sample size, which limits the extent to which conclusions can be drawn about peoples' experiences of MFT. However, the findings from this study suggest that the ongoing development of community ED services for youth could be usefully informed by larger controlled studies of MFT in this setting.

Conclusion and Recommendations

This project concludes MFT is a feasible intervention to offer in dedicated community ED services and is a valuable addition to the treatment pathway for young people with AN. Further developments have been recommended to implement MFT more effectively in this setting: 1) community ED services should have protected time for offering MFT; 2) MFT should be offered as a rolling programme, which will enable young people to attend MFT when it is most appropriate for their recovery and will allow for consideration of effective group composition; 3) Non-therapist facilitated space should be provided in MFT groups to promote group cohesion; 4) Follow-up sessions should be offered on an as-needs basis; 5) Sibling days should be routinely included in the MFT programme; 6) Individual goal-based outcomes should be used to monitor attendees progress; 7) Facilitators should be offered regular opportunities to provide this intervention to enhance their skill and flexibility in delivering the model; and 8) Facilitators should be provided with appropriate clinical supervision.

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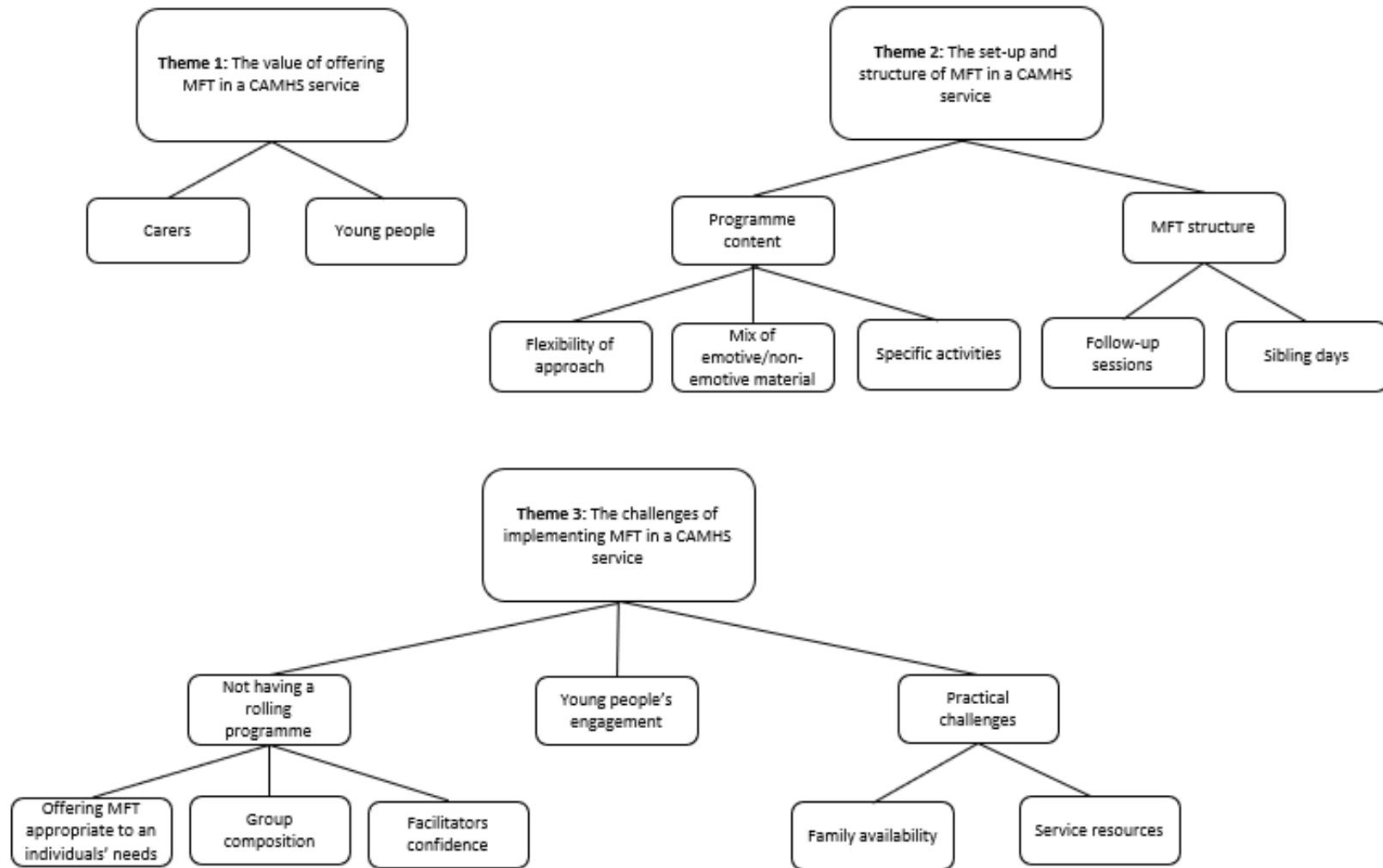White, M. & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: W.W. Norton

Figure V. Themes identified from focus-groups with therapists and carers