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PROCESS EVALUATION OF THE TRANSVERSAL CARE MODEL FOR CHILDREN AND YOUNG PEOPLE WITH EATING DISORDERS IN BELGIUM

EVALUATION STUDY PROTOCOL



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LIST OF ABBREVIATIONS

ABBREVIATION	DEFINITION
AN	Anorexia nervosa
ADH – HJA	Anonymous Day Hospitalisation *(Anonieme Daghospitalisatie – Hospitalisation de Jour Anonyme)*
APR-DRG	All Patient Refined Diagnosis Related Group
ARFID	Avoidant/restrictive food intake disorder
AZV – SHA	Anonymous Hospital Stays *(Anonieme Ziekenhuisverblijven – Séjours Hospitaliers Anonymes)*
BED	Binge eating disorder
BMI	Body mass index
BN	Bulimia nervosa
CBT-ED	Eating-disorder-focused cognitive behavioural therapy
CCG – SSM	Mental Health Centres *(Centra voor Geestelijke Gezondheidszorg – Services de Santé Mentale)*
CEPIA	Centre d'Expertise francophone sur le Poids, l'Image du corps et l'Alimentation
CFIR	Consolidated Framework for Implementation Research
CI	Confidence interval
CLB – PMS	School Guidance Centres *(Centrum voor Leerlingenbegeleiding – Centres Psycho-Médico-Sociaux)*
COMGGKJ – COMSMEA	Committee for the New Mental Health Policy for Children and Young People *(Comité voor een nieuw Geestelijk Gezondheidsbeleid voor Kinderen en Jongeren – Commission pour la nouvelle politique de Santé Mentale pour Enfants et Adolescents)*
DALY	Disability-adjusted life year
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth edition
DSM-5-TR	Diagnostic and Statistical Manual of Mental Disorders, Fifth edition, Text Revision
ED	Eating disorder
EDNOS	Eating disorder not otherwise specified
EPCAP	Evaluation of Primary care Psychology in Belgium
EPS	Permanent Sample *(Permanente Steekproef – Echantillon Permanent)*
ESEMeD	European Study of the Epidemiology of Mental Disorders
FPS	Federal Public Service *(Federale Overheidsdienst – Service Public Fédéral)*
FT-AN	Anorexia-nervosa-focused family therapy
FT-BN	Bulimia-nervosa-focused family therapy
FTE	Full-time equivalent
GDPR	General Data Protection Regulation
GGKJ – SMEA	Mental health for children and adolescents *(Geestelijke gezondheid voor kinderen en jongeren – Santé mentale pour les enfants et adolescents)*

GP	General practitioner
HIS	Health Interview Survey
ICD-11	International Classification of Diseases
IMA – AIM	Intermutualistic Agency *(Intermutualistisch Agentschap – Agence Intermutualiste)*
IMC – CIM	Interministerial Conference *(Interministeriële Conferentie – Conférence Interministérielle)*
iMFT	Intensive multi-family therapy
IVC – CSI	Information Security Committee (*Informatieveiligheidscomité – Comité de la Sécurité de l'Information*)
IQR	Interquartile range
MAST – EMAS	Multidisciplinary outpatient support teams *(Multidisciplinair ambulant support team – Équipe multidisciplinaire ambulatoire de soutien)*
MBS	Medicare Benefits Schedule (Australia)
MFT	Multi-family therapy
MRC	Medical Research Council
MPG – RPM	Minimal Psychiatric Data *(Minimale Psychiatrische Gegevens – Résumé Psychiatrique Minimum)*
MZG – RHM	Minimal Hospital Data *(Minimale Ziekenhuisgegevens – Résumé Hospitalier Minimum)*
NEDC	National Eating Disorders Collaboration
NICE	National Institute for Health and Care Excellence
NPS	Net Promotor Score
OSFED	Other Specified Feeding or Eating Disorders
PAAZ – SPHG	Psychiatric department in a general hospital *(Psychiatrische Afdeling in een Algemeen Ziekenhuis – Service de psychiatrie d'un hôpital général)*
PT	Part-time
PZ	Psychiatrisch ziekenhuis
RIZIV – INAMI	Insurance Committee of the National Institute for Health and Disability Insurance *(Rijksinstituut voor ziekte- en invaliditeitsverzekering – Institut national d'assurance maladie-invalidité)*
RE-AIM	Reach, Effectiveness, Adoption, Implementation, Maintenance
SCOFF	Sick, Control, One Stone, Fat, Food
TCT	Technical Cell (*Technische Cel – Cellule Technique)*
UFED	Unspecified feeding or eating disorder
UI	Uncertainty interval
ULB	Université Libre de Bruxelles
WHO	World Health Organization

LEXICON

TERM	DEFINITION USED IN THIS EVALUATION STUDY PROTOCOL
Adolescents and young adults	The population included in the process evaluation: individuals aged 10 to 24 years.
Children and young people	The target population defined in the RIZIV-INAMI agreements: individuals up to 24 years of age at inclusion in the transversal care model.
Context	External and internal factors that influence implementation and functioning of the interventions.
ED reference centre	A healthcare organisation formally recognised by RIZIV-INAMI to provide specialised eating disorder care and supra-regional expertise. The RIZIV-INAMI agreements use the official term “centres with a reference function for ED”. To improve readability, this protocol consistently refers to these centres as “ED reference centres”.
GGKJ-SMEA network	Regional mental health network for children and young people responsible for organising and coordinating several interventions within the care model.
Implementation	The extent to which an intervention is delivered and used as intended, including reach, adoption, fidelity, and sustainability.
Intervention A	Training programme for healthcare professionals involved in eating disorder care.
Intervention B	Eating disorder care pathway providing coordinated multidisciplinary outpatient care.
Intervention C	Multidisciplinary outpatient support teams within GGKJ-SMEA networks.
Intervention D	Ambulatory part-time treatment programmes within GGKJ-SMEA networks.
Intervention E	Supra-regional multidisciplinary outpatient support teams attached to ED reference centres.
Intervention F	Part-time treatment programmes organised within ED reference centres.
Mechanisms of change	Processes through which interventions are expected to influence care delivery, experiences, and perceived outcomes.
Parent or legal guardian	Parent(s) or legal representative(s) involved in the care and support of a service user.
RIZIV-INAMI agreements	The formal agreements that regulate the implementation, financing, responsibilities, and operational arrangements of the transversal care model.
Service user	Any child, adolescent, or young adult receiving care within one or more interventions of the transversal care model. This term is used instead of “patient” when referring to experiences across care settings and evaluation activities.
Transversal care model for eating disorders	The overarching Belgian organisational and clinical framework for prevention, early identification, treatment, coordination, and continuity of care for children and young people with eating disorders.

SCIENTIFIC REPORT

1 INTRODUCTION

KEY POINTS

- Since December 2022, the Belgian Interministerial Conference (IMC-CIM) endorsed the development of a transversal care model for children and young people with eating disorders (EDs). To support its implementation, 10 million euros per year has been allocated through the compulsory health insurance budget since 2023.
- This model was based on recommendations from the Committee for the New Mental Health Policy for Children and Young People (COMGGKJ-COMSMEA), which advocate for a population oriented healthcare system that strengthens prevention and promotes wellbeing; enables early detection and intervention; and provides high-quality, person-centred care for children and young people with EDs.
- Although tailored to the Belgian healthcare context, the model draws on international evidence and good practices. In particular, the Australian stepped care model served as an important reference framework, integrating prevention, early intervention, community-based care, intensive treatment, and hospital care within a coordinated continuum of care.
- This document presents the process evaluation study protocol for the transversal care model for children and young people with EDs.

1.1 Context

On 14 September 2022, the federal government and the Regions and Communities agreed to develop a **transversal integrated care model for children and young people with eating disorders** (EDs).[1] This initiative was established as an integrated care project with the aim of transforming how care for EDs is organised and delivered in Belgium.

The model builds on recommendations developed by the Committee for the New Mental Health Policy for Children and Young People (COMGGKJ-COMSMEA).[2] These recommendations respond to the need for a population-oriented healthcare system that:

- strengthens prevention and empowers children and young people to protect their mental health;
- enables early detection at the first signs of EDs;
- delivers high-quality, tailored care for individuals with EDs.

According to COMGGKJ-COMSMEA, addressing these priorities will lead to better health outcomes, improved wellbeing, less suffering, and lower social and financial costs.[2]

Meeting these objectives requires a comprehensive and well-coordinated service landscape. All relevant actors must collaborate across sectors and disciplines to guarantee continuity of care within each care pathway, across different types of EDs, and throughout all age groups.

On 14 December 2022, the Belgian Interministerial Conference (IMC-CIM) endorsed the development of a transversal care model for EDs covering all levels of care, from prevention to highly specialised treatment. To support implementation, **10 million euros per year have been allocated from 2023 onwards** within the compulsory health insurance budget. This investment complements existing federal, regional, and community initiatives and forms part of the broader policy framework established by the IMC-CIM agreement of 14 December 2022. It was explicitly agreed that federal and federated investments would be complementary and mutually reinforcing.

1.1.1 Stepped system of care for eating disorders in Australia

To inform the development of the Belgian care model for EDs, COMGGKJ-COMSMEA reviewed international examples of good practice. Particular attention was given to the **stepped system of care developed in Australia**, which offers a comprehensive framework for organising prevention, early intervention, treatment, and recovery support across different levels of care. The model served as an important **reference point for the design of the Belgian transversal care model for EDs**.

The Australian National Eating Disorders Collaboration (NEDC) has developed a stepped care model for EDs (Figure 1). This model describes the different types and intensities of care that people may need throughout the course of illness and recovery. A stepped continuum of care is widely supported by expert consensus as the optimal approach.[2] It provides a full range of service intensities, guided by skilled assessment and supported by smooth transitions between services as a person's needs change. In this framework, treatment is coordinated, evidence-based, and adjusted up or down according to psychological, physical, nutritional, and functional needs. Importantly, movement across levels of care is not linear, people may require repeated episodes of treatment at various levels and from different providers.[3]

The Australian stepped system of care is informed by evidence-based treatment guidelines, stepped-care principles, lived-experience expertise, and ongoing research and evaluation. Rather than introducing a new therapeutic intervention, the model aims to improve access to and coordination of evidence-based multidisciplinary care by matching the level and intensity of care to individuals' changing needs throughout illness and recovery. The model emphasises coordinated care pathways, multidisciplinary collaboration, and continuity of care across treatment settings.

Prevention and early detection are central to this approach. Early identification and follow-up depend on strong regional collaboration between mental health professionals, GPs, primary care providers, schools, social workers, youth health services, and other community partners.

Treatment can take place across multiple settings, including outpatient services, intensive or day programmes, and inpatient care. The appropriate level of care is determined by the severity and complexity of the ED. Outpatient care may occur in primary care or specialised services, whereas more severe presentations may require day treatment, medical admission, or psychiatric inpatient care. The stepped care system also emphasises ongoing monitoring and evaluation, enabling clinicians to increase treatment intensity when required.

- **Community-based treatment:** this is the first level of intervention and involves delivering evidence-based treatment in community or outpatient settings. Services may include psychological treatment, medical monitoring, nutritional support, and dietetic care provided by GPs, mental health professionals, and allied health professionals. In some cases, appropriately trained primary healthcare providers may also provide guided self-help or digital interventions. This level of care is typically suitable for people with mild to moderate symptom severity who are medically stable and able to engage in treatment while continuing daily activities. Community-based treatment may be offered following early identification of symptoms, as ongoing longer-term treatment, or as step-down after more intensive community or hospital-based care.
- **Community-based intensive treatment:** this level provides care at a higher frequency and intensity of support than standard outpatient or community-based treatment, while still allowing the person to remain living in the community.[a] Treatment is generally delivered through intensive outpatient programmes, structured day programmes, or outreach interventions, and usually involves more frequent multidisciplinary input, supervision, and meal support. This level is intended for individuals whose symptoms are too severe or complex for standard outpatient

[a] Community-based treatement includes public and private ED-specific services, as well as community mental health services for children, adolescents, youth, and adults.

treatment alone, but who do not currently require inpatient admission. It may be used as an early intervention for individuals with rapidly escalating symptoms, as a step-up when standard community treatment is insufficient, or as a transition from hospital-based treatment back into the community. Peer workers may contribute to support and recovery at this stage.

- **Hospital treatment:** hospital-level care is required when individuals need medical and/or psychiatric stabilisation, or when they require a residential ED programme due to severe symptoms despite medical stability. Treatment can be delivered in emergency departments, medical or psychiatric inpatient units, ED-specific inpatient units, hospital-at-home programmes, rehabilitation units, or ED residential programmes. Hospital treatment may also be needed at first diagnosis for individuals at high medical or psychiatric risk. It may also serve as a step up for acute intervention or access to structured, intensive programmes.

Across all stages of the continuum, care should be delivered by a multidisciplinary team that includes, at minimum, medical and mental health professionals. Depending on the person's need, the care team may also include dietitians, psychiatrists, nurses, occupational therapists, social workers, peer support workers, and other allied health professionals. Families and support networks remain integral members of the care team.

In 2019, the Australian Government introduced specific Eating Disorders Medicare Benefits Schedule (MBS) items. These items provide a funding mechanism for assessment, psychological and dietetic interventions, and treatment reviews for eligible individuals with EDs. The MBS items are an important component of the broader Australian stepped model of care, but do not constitute the model itself. Rather, they support access to multidisciplinary treatment delivered within this framework.[4, 5]

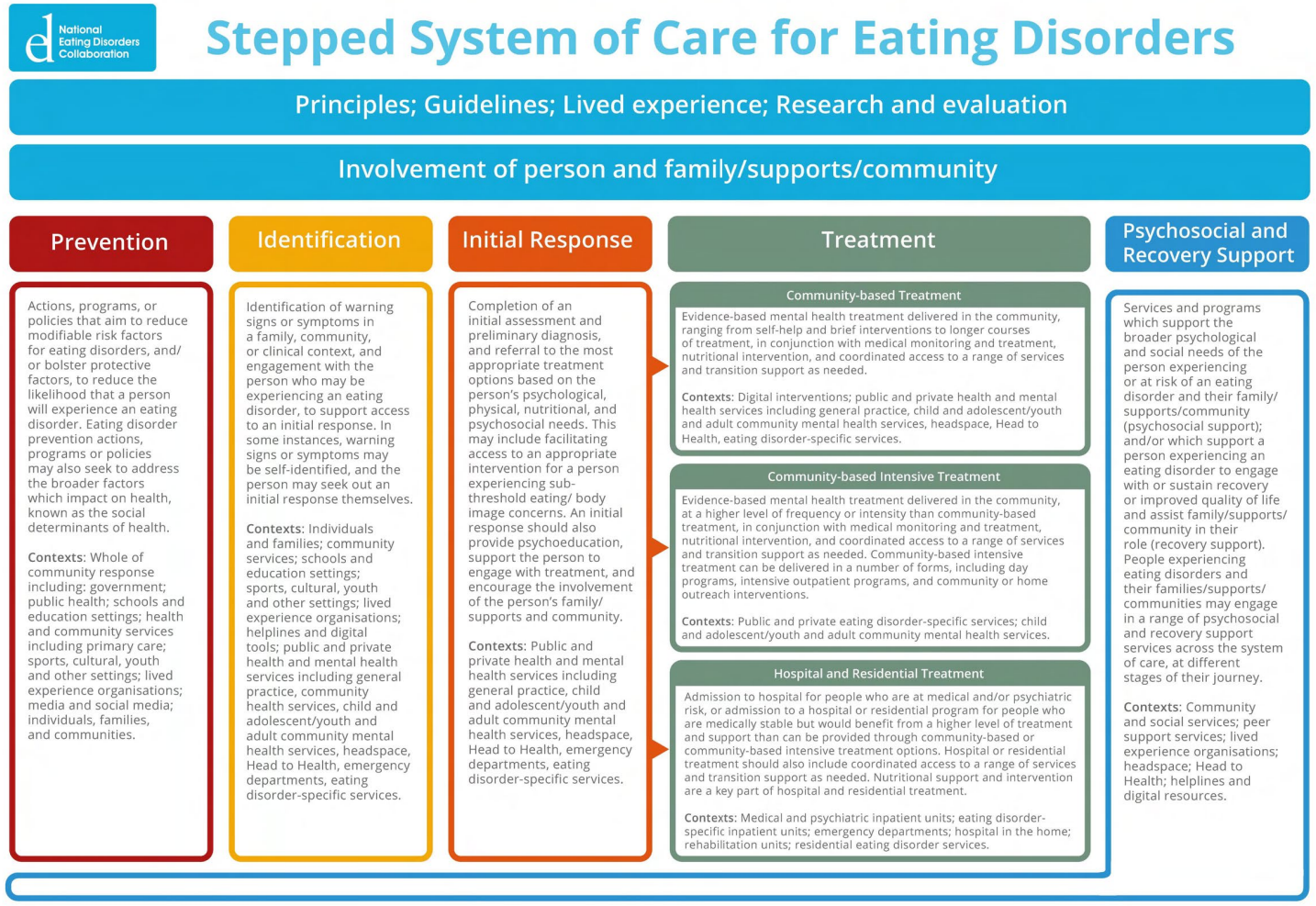
Evidence regarding the implementation of the Australian approach is promising, although still evolving. A national evaluation of the Eating Disorder MBS items reported improvements in ED symptoms, psychological distress, and goal attainment over the course of treatment. Most service users indicated that care received under an Eating Disorder Plan was wholly or partly responsible for these improvements. However, outcome data were incomplete and inconsistently available, limiting the extent to which firm conclusions can be drawn regarding the effectiveness of the overall stepped-care model.[4]

Additional evidence from an Australian regional implementation study demonstrated that a coordinated multidisciplinary approach delivered in non-specialist settings was associated with high treatment completion rates, significant reductions in ED psychopathology, and remission rates comparable to those reported in specialist clinical trials.[6]

At the service level, evidence from a large-scale health system reform implemented in New South Wales showed increased treatment provision and changes in service utilisation during the first five years of implementation. The reform was also associated with improvements in care pathways, multidisciplinary communication, and recognition of EDs as a core component of health service delivery. These findings support the feasibility of implementing a coordinated, system-wide approach to ED care, although they do not establish effectiveness in terms of patient outcomes.[7]

When interpreting this stepped care system, it is important to consider the distinct distribution of healthcare responsibilities in Australia compared to Belgium. While both countries have a federal structure, the allocation of responsibilities differs. In Australia, the Australian Government is primarily responsible for the organisation and financing of primary care. In contrast, State and Territory Governments have constitutional responsibility for the delivery of health services and for managing the public health system, including hospitals. They operate and fund public secondary and tertiary care through state-run hospitals and hospital networks.

Figure 1 – Stepped system of care for eating disorders in Australia



Source: National Eating Disorders Collaboration[3]

Note: The infographic shown here is a slightly updated version from 2023, replacing the earlier 2021 version included in the COMGGKJ-COMSMEA recommendations.

1.2 Scope of this evaluation study protocol

This document presents the protocol for a **one-time process evaluation commissioned by RIZIV-INAMI**. The evaluation aims to inform decision-making regarding the current transversal care model for children and young people with EDs, which ends in 2028. The focus is on implementation, mechanisms of change, context, and perceived effectiveness. The document is not intended as a long-term monitoring framework, although some tools and reporting structures developed within this protocol may subsequently support future monitoring activities or future agreements.

While an impact or outcome evaluation would normally be the preferred approach for assessing whether the transversal care model achieves its intended effects for children, young people, and their families, a process evaluation was selected for the current evaluation study. An important policy need is to understand how the six interventions in the transversal care model have been implemented across different settings and regions, how stakeholders experienced the care model, and which contextual factors facilitated or hindered implementation. This focus is particularly relevant in view of the current agreement period, which ends in 2028 and for which RIZIV-INAMI requires evidence to inform future decision-making.

Furthermore, **a robust effect evaluation was not feasible due to several methodological constraints**, including the absence of systematic baseline data, the lack of suitable comparison groups, and the heterogeneity in implementation across interventions and settings. Therefore, this present evaluation study protocol focuses on implementation processes, mechanisms of change, contextual influences, and stakeholders' perceptions of the care model. Nevertheless, the development of adequate outcome measurement systems and data infrastructure should be considered a priority, enabling a future impact evaluation to assess the effectiveness and added value of the transversal care model more robustly.

While Chapters 1 to 3 describe the background, rationale, and operational characteristics of the transversal care model for children and young people with EDs, the remainder of this document details the process evaluation protocol. It describes the conceptual framework, methodological choices, data sources, and analytical approach that will be used to evaluate the implementation of the six interventions included in the care model.

Chapter 1 introduces the policy context of the transversal care model in Belgium. Chapter 2 provides background information on EDs and their burden. Chapter 3 describes the interventions included in the transversal care model and discusses the main implementation characteristics and evaluation constraints. Chapter 4 presents the evaluation framework, including the logic model and the theoretical foundations of the process evaluation. Chapter 5 operationalises this framework by detailing the design, data sources, data collection methods, and analytical approach.

2 BACKGROUND

KEY POINTS

- EDs are **serious psychiatric disorders**, which are characterised by a "persistent disturbance of eating or eating-related behaviour that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning".
  - **Anorexia nervosa** (AN) is defined by an intense fear of weight gain or a disturbed body image, or both, which drive extreme dietary restriction or other weight loss behaviours;
  - **Bulimia nervosa** (BN) is characterised by recurring episodes of binge eating followed by inappropriate compensatory behaviours to prevent weight gain;
  - **Binge eating disorder** (BED) is characterised by distressing, recurring episodes of binge eating, distinguished from bulimia nervosa by a significantly lower frequency of compensatory actions;
  - The diagnostic category '**other specified feeding or eating disorder**' (OSFED) encompasses people with EDs who do not meet full criteria for any of the ED categories.
- EDs impact all aspects of a person's life in a significant manner.
- Although EDs can develop at any age, their development peaks during the mid-to-late adolescent period.
- EDs are more common in females than males.
- The treatment of EDs in children and young people mainly focuses on psychological therapy and in individuals with AN, dietary advice as part of a multidisciplinary approach.

2.1 What are eating disorders and how to identify them?

2.1.1 Definitions

Eating disorders (EDs) are serious psychiatric disorders that, according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR), are characterised by a "**persistent disturbance of eating or eating-related behaviour** that results in the **altered consumption or absorption of food** and that significantly impairs physical health or psychosocial functioning".[8] Disturbed attitudes regarding weight, body shape, and eating are instrumental in their origin and maintenance.[9] All EDs significantly compromise physical health and disrupt psychosocial functioning.[10]

The DSM-5 and the International Classification of Diseases (ICD-11) encompass six main feeding and EDs.[8, 11] Yet, the transversal care model under evaluation, as specified in this protocol, focuses on the following EDs:

- **Anorexia nervosa** (AN) is a severe psychiatric condition defined by an intense fear of weight gain or a disturbed body image, or both. These psychological factors drive extreme dietary restriction or other weight loss behaviours (e.g. purging, excessive physical activity).[9]
- **Bulimia nervosa** (BN) is characterised by recurring episodes of binge eating (i.e., the consumption of unusually large quantities of food accompanied by a profound sense of loss of control), followed by inappropriate compensatory behaviours to prevent weight gain.[12] The predominant compensatory behaviour is self-induced vomiting, but inappropriate use of medicines, fasting, or excessive physical exertion are also frequently observed.[9]

- **Binge eating disorder** (BED) is characterised by distressing, recurring episodes of binge eating, distinguished from bulimia nervosa by a significantly lower frequency of compensatory actions.[13] BN and BED frequently co-occur with, or lead to, obesity and related metabolic disorders.[b 9]

Some interventions of the transversal care model also address children and young people with '**other specified feeding or eating disorder**' (OSFED). This category encompasses people with EDs who do not meet full criteria for any of the ED categories.[14] According to DSM-5-TR, OSFED consists of several sub-diagnoses, including atypical AN, purging disorder, night eating syndrome, and subthreshold BN and -BED.[8] More details are provided in Appendix 1.1.

2.1.2 Aetiology

Although the exact aetiology of EDs is still unclear, it is well established that their development stems from a complex interplay of biological, psychological, social, cultural factors and environmental determinants (e.g. geographic location and surrounding nutritional environments).[15-18]

Specific factors that have been linked to the development of (symptoms of) EDs include low body mass index (BMI), childhood trauma, poor family environment, excessive parental weight preoccupation, peer relationship stress, personality traits (negative emotionality, perfectionism, negative urgency or the tendency to act impulsively while distressed) and sociocultural idealisation of ideal body size.[19-25]

2.1.3 Diagnosis

People affected by EDs require prompt clinical evaluation and timely intervention at the earliest opportunity to optimise recovery outcomes.[26] The National Institute for Health and Care Excellence (NICE) provides in its guidance on the diagnosis and treatment of EDs a long list of signs, symptoms and other points of particular attention when assessing for an ED or deciding whether to refer people for assessment (Box 1).[26] They further warn that in addition to the points listed in Box 1, children and young people with an ED may also present with faltering growth (e.g. a low weight or height for their age) or delayed puberty.[26]

Box 1 – Signs, symptoms and other factors hinting at eating disorders (NICE)

- An unusually low or high body mass index (BMI) or body weight for their age;
- Rapid weight loss;
- Dieting or restrictive eating practices (such as dieting when they are underweight) that are worrying them, their family members or carers, or professionals;
- Family members or carers report a change in eating behaviour;
- Social withdrawal, particularly from situations that involve food;
- Other mental health problems;
- A disproportionate concern about their weight or shape (for example, concerns about weight gain as a side effect of contraceptive medication);
- Problems managing a chronic illness that affects diet, such as diabetes or coeliac disease;
- Menstrual or other endocrine disturbances, or unexplained gastrointestinal symptoms;

[b] Of note, obesity per se is not classified as a formal eating disorder within current psychiatric diagnostic framework.[9]

- Physical signs of:
  - malnutrition, including poor circulation, dizziness, palpitations, fainting or pallor;
  - compensatory behaviours, including laxative or diet pill misuse, vomiting or excessive exercise;
- Abdominal pain that is associated with vomiting or restrictions in diet, and that cannot be fully explained by a medical condition;
- Unexplained electrolyte imbalance or hypoglycaemia;
- Atypical dental wear, more precisely erosion;
- Whether they take part in activities associated with a high risk of EDs (for example, professional sport, fashion, dance, or modelling).

The **diagnostic criteria** for AN, BN and BED as provided in the DSM-5-TR, are presented in Table 1.[8] These criteria have undergone significant expansion, marked by the relaxation of the weight threshold for AN, the reduction of required behavioural frequencies for BN, and an overall increase in the number of formally recognised EDs.[8] This update reduced the number of EDs classified as "other specified" groups, yet, it has also been criticised because the expected clinical benefits (i.e. better symptom specificity and clearer severity-based differences) fell short of expectations.[27]

Table 1 – Diagnostic criteria for anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder (BED)

Diagnostic criteria	
Anorexia nervosa (AN)	
Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.	
Intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain, even though at a significantly low weight.	
Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.	
Subtypes	• Restricting type • Binge-eating/purging type
Bulimia nervosa (BN)	
Recurrent episodes of binge eating. An episode of binge eating is characterised by both of the following: • Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances. • A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating).	
Recurrent inappropriate compensatory behaviours in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.	
The binge eating and inappropriate compensatory behaviours both occur, on average, at least once a week for 3 months.	
Self-evaluation is unduly influenced by body shape and weight.	

Diagnostic criteria
The disturbance does not occur exclusively during episodes of AN.
Binge-eating disorder (BED)
Recurrent episodes of binge eating. An episode of binge eating is characterised by both of the following: • Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances. • A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating).
The binge eating episodes are associated with three (or more) of the following: • Eating much more rapidly than normal • Eating until feeling uncomfortably full • Eating large amounts of food when not feeling physically hungry • Eating alone because of feeling embarrassed by how much one is eating • Feeling disgusted with oneself, depressed, or very guilty afterward
Marked distress regarding binge eating is present.
The binge eating occurs, on average, at least once a week for 3 months.
The binge eating is not associated with recurrent use of inappropriate compensatory behaviou***r*** as in BN and does not occur exclusively during the course of BN or AN.

Source: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR)[8]

2.1.4 Onset and consequences

Although EDs can develop at any age, their development peaks during the mid-to-late adolescent period.[26, 28-30] This period of life is characterised by intense biopsychosocial changes and by starting to experience emotions related to appearance and may begin comparing themselves with others and/or unrealistic body ideals.[31] While an increased interest in appearance and body image is developmentally normal for adolescents, such behaviour needs to be regarded as alarming once significant weight changes or overly restrictive dietary habits emerge.[32]

The onset of EDs in **childhood** is **particularly precarious** due to its potential rapid escalation.[16, 33-35] Additionally, occurrence of disordered ED behaviours early on in life significantly increases the risk of developing full-syndrome EDs in later adolescence and early adulthood.[33, 35, 36]

The altered eating patterns are often associated with (strong) weight fluctuations and can induce **deleterious effects** on nutrition, physical growth and cognitive, social and psychological development.[16, 32-35] All these aspects negatively impact the quality of life and social adaptation of people suffering from EDs.[37-40]

Physical health complications, such as impacts on the cardiovascular system, as well as increased suicide rates (especially in those with a comorbid psychiatric disorder) lead to a significantly higher mortality rate in patients suffering from EDs when compared to the general population.[41-45] Additionally, bidirectional comorbidities have been shown between EDs and a broad range of other psychiatric disorders such as neurotic, personality and mood disorders.[46]

2.2 Treatment of eating disorders

The treatment of EDs in children and young people mainly focuses on **psychological therapy** (e.g. eating-disorder-focused cognitive behavioural therapy (CBT-ED), anorexia-nervosa-focused family therapy, bulimia-nervosa-focused family therapy (FT-AN, FT-BN)) and in individuals with AN, dietary advice as part of a multidisciplinary approach.[26] According to the NICE guidance, no medication should

be offered as the sole treatment in any of the EDs under study.[26] Furthermore, physical therapy (such as transcranial magnetic stimulation, acupuncture, weight training, yoga or warming therapy) should not be offered as part of the treatment for EDs.[26]

For children and young people with OSFED, NICE recommends that clinicians consider using the treatments for the ED it most closely resembles.[26]

Given the diversity in presentations between the different EDs, the responses to different therapies will also vary. Consequently, a correct categorisation based on the specific symptomatology is crucial to enable the implementation of appropriate interventions.[27]

Despite the availability of evidence-based treatments, a large proportion of EDs remain **undetected and untreated.** [9, 47-49] This results in serious consequences for physical, psychological, and social functioning.[9, 50] Poor outcomes for EDs are also seen in those seeking help and receiving care due to the negative impact of a long delay between illness onset and reception of treatment.[51-53]

The **delay between the first symptoms and the effective reception of treatment** is estimated to be approximately 2.5 years for AN, 4.5 years for BN and more than 5.5 years for BED, according to a systematic review based on data in seven countries (Australia, Canada, Germany, Ireland, Singapore, Spain and the UK).[54]

2.3 Prevalence of eating disorders

2.3.1 Global prevalence data

According to the Global Burden of Disease study[c] (2023), the global prevalence of AN and BN increased significantly from 2019 to 2023.[d] [55] For AN the increase was somewhat higher in females than in males (58.2%, 95% UI: 54.1 to 62.9 vs. 56.5%, 95% UI: 52.3 to 62.0), while the inverse was observed for BN (73.6%, 95% UI: 66.5 to 81.7 vs. 78.2%, 95% UI: 70.8 to 87.8).[55] Yet, the researchers noted that the global rises in the age-standardised prevalence and disability-adjusted life year (DALY[e]) rates of mental disorders were primarily driven by substantial increases in anxiety disorders and major depressive disorder, while more modest upward trends were observed for other mental disorders like AN and BN.[55] Studies conducted worldwide have estimated the lifetime prevalence of AN to range from 0.5% to 2.0%, whereas respective data for BN range between 0.9% and 3.0%.[32, 57, 58]

A recent systematic review and meta-analysis which included sixteen studies from twelve countries estimated that the pooled point **prevalence of EDs in children and young people** "worldwide" was 5.23% (95% confidence interval (CI): 0.41 to 10.05), with girls being more frequently affected than

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c The Global Burden of Disease study is based on a systematic literature review developed to identify epidemiological data (on mental disorders), and which is updated on a rolling basis.[55] Mental disorders have to be identified "*through clinical evaluations or completion of an established instrument broadly adhering to DSM or ICD classifications*". The 2023 GBD study does not provide data on other EDs, such as BED or OSFED.[55]

d The global prevalence of AN increased from 2.49 million (95% uncertainty interval (UI): 1.76 to 3.43) in 1990 to 3.92 million (95% UI: 2.78 to 5.30) in 2023, which corresponds to a 57.9% increase (95% UI: 54.0 to 62.5). A similar increase is observed for bulimia nervosa (from 8.10 million (95% UI: 5.63 to 11.8) in 1990 to 14.2 million (95% UI: 10.2 to 20.2) in 2023, which corresponds to a 75.1% increase (95% UI: 68.0 to 83.7).[55]

e In the GBD study, health burden is quantified using the disability-adjusted life-year (DALY), which combines the non-fatal and fatal consequences of diseases and injuries. One DALY represents one healthy year of life lost to a cause.[56]

boys (7.12%, 95% CI: 0.00 to 15.64 vs. 2.99%, 95% CI: 0.00 to 6.21). [f] [58] The most common type was OSFED (prevalence: 4.88%, 95% CI: 1.46 to 8.30), followed by BN (prevalence: 1.11%, 95% CI: 0.04 to 2.19) and AN (prevalence: 0.54%, 95% CI: 0.12 to 1.17; no pooled data provided for BED).[58] The authors further noticed that five studies had a high risk of bias and that there was considerable heterogeneity among the studies.[58]

2.3.2 Belgian prevalence data

The 2013, 2018 and 2023 nationwide **Health Interview Surveys** (HIS, see also Box 2) provide recent data on (self-)reported mental disorders, among which AN, BN and BED (the latter restricted to 2023).[59] In the survey, living with an ED is assessed with the Sick, Control, One Stone, Fat, Food (SCOFF) questionnaire, which consists of five yes/no questions regarding weight loss, disordered eating behaviour and cognitions, and body image.[g] [60] Due to the sensitive nature of EDs, the SCOFF questions were incorporated exclusively into the self-administered questionnaire and restricted to participants aged 15 and older.[65]

Box 2 – The Belgian Health Interview Survey (HIS)

The Health Interview Survey (HIS) is an initiative of Sciensano and consists of a cross-sectional population survey through face-to-face interviews and self-administered questionnaires among a representative sample of approximately 10 000 individuals living in Belgium.[66] The survey was first launched in 1997 and was repeated every 4 to 5 years since then. The purpose of this survey is to provide an overall picture of the health status of the Belgian population and to identify the main health problems, as well as the social and behavioural factors that influence them. The latest (and seventh) Health Survey was started in 2023 and data were published in 2025).[67, 68]

In 2023, the overall prevalence of reported AN/BN was 7.8% [CI 6.8 to 8.9], with a **lower** prevalence in **men compared to women** (5.7%, 95% CI 4.5 to 6.9 vs. 9.9%, 95% CI 8.2 to 11.6; Figure 1 in Appendix 1.2). Likewise, the prevalence of reported BED was somewhat lower in men compared to women (9.4%, 95% CI 8.0 to 10.9 vs. 10.0%, 95% CI 8.6 to 11.5; Figure 2 in Appendix 1.2).[59] Both in 2018 and in 2023, there was an **inverse relationship** between reported AN/BN prevalence and **age** (Figure 3 in Appendix 1.2). This inverse relationship was also observed for reported BED (Figure 4 in Appendix 1.2).[59]

In 2023, the highest prevalence of reported BED was observed in Flanders (10.6%, 95% CI 9.2 to 12.0), followed by the Brussels Capital region (9.3%, 95% CI 6.9 to 11.8) and Wallonia (7.9%, 95% CI 6.0 to 9.8; Figure 6 in Appendix 1.2). Remarkably, the opposite was noted for reported AN/BN, with the highest prevalence in the Walloon region (11.4%, 95% CI 8.8 to 14.1) and the lowest in the Flemish region (6%, 95% CI 4.9 to 7.0; Figure 5 in Appendix 1.2). Of note, the prevalence in the Brussels Capital region decreased substantially from 12.6% in 2013 to 9.3% (95% CI 6.8 to 11.8) in 2023, yet no explanation for this observation is provided.[59]

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[f] These results are based on studies published after 2013 which were mostly conducted in European countries and the United Kingdom (n = 7), followed by Iran (n = 3), United States (n = 2), Burkina Faso (n = 1), Canada (n = 1) and Australia (n = 1).

[g] The SCOFF questionnaire comprises the following five questions: 1. Have you recently lost 6 kilos or more in a 3-month period? 2. Do you worry that you have lost control over how much you eat? 3. Do you make yourself sick because you feel uncomfortably full? 4. Do people say you are too thin while you believe yourself to be too fat? 5. Would you say that food dominates your life? The presence of an ED is presumed when two or more questions are answered affirmatively.[60] The SCOFF questionnaire has been validated in several languages and populations, but to the best of our knowledge, a validation study of the Dutch version has not yet been performed.[61-64]

According to the most recent wave of the **Food Consumption Survey** (2022-2023; Box 3), 12.2% (95% CI 10.3 to 14.1) of participants aged 10 to 64 years old reported an ED.[69] Again, the prevalence was higher in women compared to men (15.4%, 95% CI 12.3 to 18.4 vs. 9.1%, 95% CI 6.8 to 11.4). The sex difference was the least pronounced in the adolescent group (10-17 years old), where 11.7% (95% CI 7.5 to 15.8) of girls reported disordered eating, against 6.9% (95% CI 3.4 to 10.4) of boys (Figure 7 in Appendix 1.2).[69]

Box 3 – The Food Consumption Survey

The Food Consumption Survey, which started in 2004, examines the eating habits, food and nutrient consumption of individuals living in Belgium. It also assesses physical activity and sedentary behaviour, as well as other nutrition-related topics such as body mass index, food security, food literacy, food safety and EDs.[69] EDs are also assessed using the SCOFF questionnaire.[g]

Participants are randomly selected from the Belgian National Register. The most recent survey, conducted in 2022 and 2023, involved almost 3000 participants aged three years and older, as well as additional samples of around 1000 individuals in Brussels and 160 in the German-speaking community.[69]

The **Sick, Control, One, Fat, Food (SCOFF) questionnaire** was included in this Food Consumption Survey but only for the participants aged **10 to 64 years** to identify individuals with a suspicion of an ED, i.e. disordered eating.[70]

Importantly, data from the Food Consumption Survey were also stratified by **educational level**. An inverse relationship was observed: whereas 15.6% (95% CI: 12.2 to 18.9) of those with the lowest education levels (secondary school or lower) reported disordered eating, the respective proportion was 9.7% (95% CI: 6.7 to 12.6) among those with the highest education levels (long-type higher education).

According to this survey, among people aged 10 to 64 years the proportion of individuals who reported an ED was highest in Brussels (17.5%, 95% CI: 13.7 to 21.3), followed by Wallonia (14.5%, 95% CI: 10.7 to 18.3) and Flanders (11.5%, 95% CI: 8.8 to 14.1).

3 OVERVIEW OF THE INTERVENTIONS INCLUDED IN THE TRANSVERSAL ED CARE MODEL

The description of the interventions in this chapter has been reviewed by Dr. Andries Van Schuerbeek and Mrs. Marleen Van Eygen, subject matter experts at RIZIV-INAMI.

KEY POINTS

- The Belgian transversal care model for EDs is developed to improve early identification, timely intervention, interprofessional collaboration, and continuity of care for children and young people with EDs.
- Implementation of the care model is governed through two complementary RIZIV-INAMI agreements, which define the target population, responsibilities, funding mechanisms, and organisational arrangements.
- The model primarily targets children and young people up to 24 years of age diagnosed with anorexia nervosa (AN), bulimia nervosa (BN), or binge eating disorder (BED), although specific interventions have broader eligibility criteria.
- The transversal care model consists of six interconnected core components spanning the entire care continuum: (i) training programme for healthcare professionals (intervention A); (ii) an ED care pathway providing coordinated multidisciplinary outpatient care (intervention B); (iii) multidisciplinary outpatient support teams within GGKJ-SMEA networks (intervention C); (iv) ambulatory part-time treatment programmes within GGKJ-SMEA networks (intervention D); (v) supra-regional multidisciplinary outpatient support teams in ED reference centres (intervention E); and (vi) part-time treatment programmes in ED reference centres (intervention F).
- The implementation of the interventions has occurred progressively since 2024, with considerable variation in timing, funding structures, organisational arrangements, and uptake across settings.
- Important heterogeneity exists across interventions and implementation sites regarding target populations, treatment intensity, service delivery models, and reporting practices. In addition, interventions may have been adapted to local contexts, while the fidelity with which they were implemented may have varied across sites. These differences have important implications for evaluation and substantially limit the feasibility of a robust effect-evaluation.
- Consequently, this chapter provides the contextual and operational information necessary to understand the interventions and to justify the subsequent focus on process evaluation rather than outcome evaluation.

Drawing inspiration from the Australian stepped system of care (see section 1.1.1), a multidimensional transversal care model was established in Belgium to facilitate the early identification and management of EDs. The care model was established in **two RIZIV-INAMI agreements**, in which the mutual responsibilities as well as the targeted healthcare providers and patients are described.[71, 72] Figure 2 provides an overview of the six interventions within the transversal ED care model. It outlines the responsible entities as well as the healthcare providers and/or patients targeted by each intervention.

Throughout this protocol, the term “transversal care model” refers to the overarching organisational and clinical framework, whereas “RIZIV-INAMI agreements” refers to the formal instruments regulating its implementation. To improve readability, the interventions are referred to throughout this research protocol using the labels shown in Table 2.

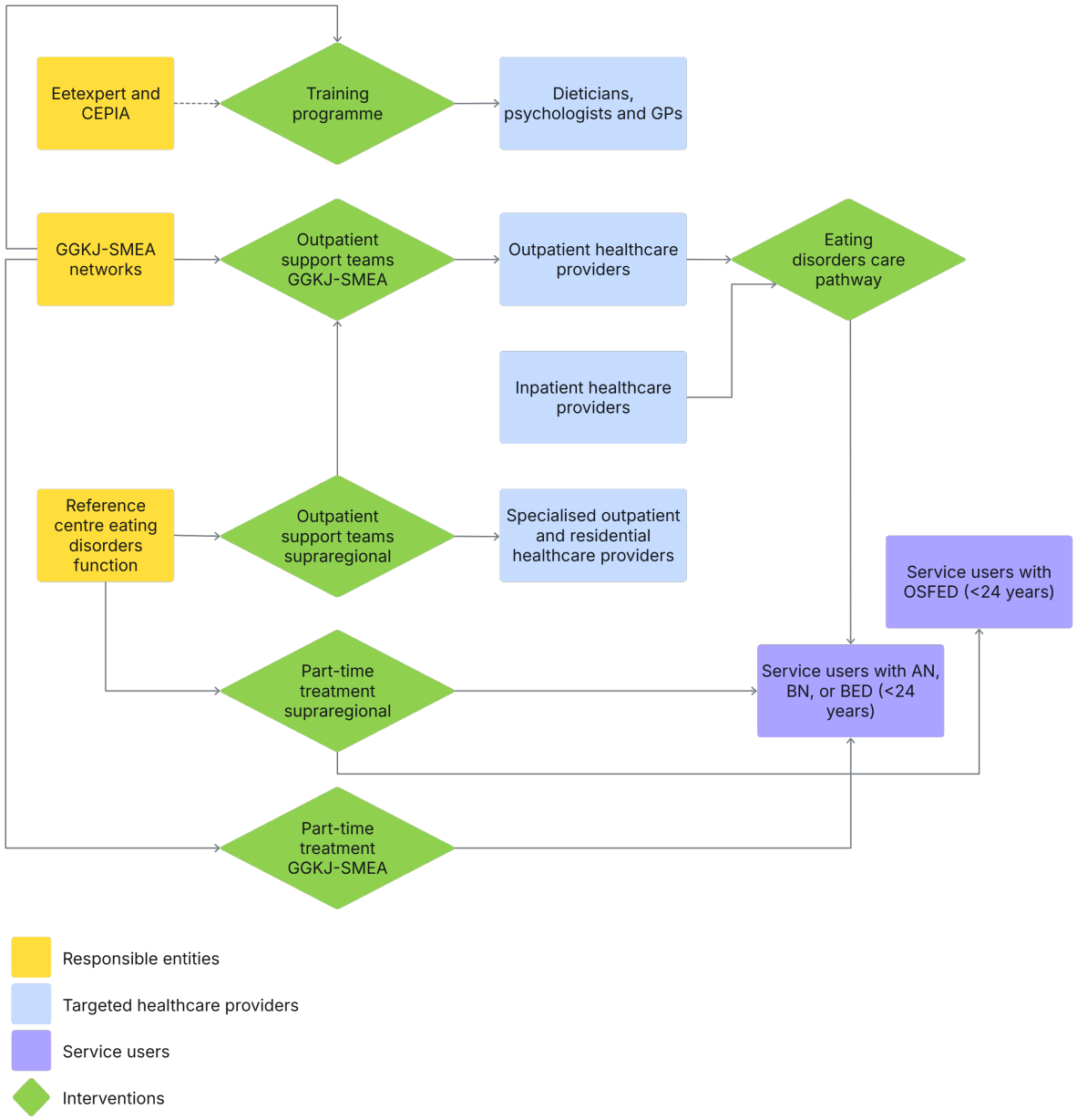
Table 2 – Overview of interventions and corresponding labels

Label	Intervention	Start date
Intervention A	Training programme	1 September 2022 – period 1 1 September 2024 – period 2 - …
Intervention B	ED care pathway	1 February 2024
Intervention C	Multidisciplinary outpatient support teams GGKJ-SMEA	1 September 2024
Intervention D	Ambulatory part-time treatment programme GGKJ-SMEA	1 September 2025
Intervention E	Supra-regional multidisciplinary outpatient support teams	1 September 2025
Intervention F	Part-time treatment programme in ED reference centres	1 September 2025

ED: eating disorder; GGKJ-SMEA: Geestelijke gezondheid voor kinderen en jongeren-Santé mentale pour les enfants et adolescents (mental health for children and adolescents)

This chapter provides the contextual foundation for the evaluation study protocol presented in the subsequent chapters by describing the interventions included in the transversal care model and highlighting the key implementation features that are relevant for their evaluation. To ensure consistency, each intervention is described using a common structure, where information is available. First, we describe the intervention, including its content, target population, stakeholders involved in delivery, objectives, and financial arrangements. Preliminary implementation data were included to document the context in which the interventions operate, assess the feasibility of proposed evaluation activities, and inform the design of the process evaluation. We also describe any expected or implemented modifications, the current level of uptake and implementation, and the reporting requirements associated with the intervention. Finally, we discuss the main methodological and practical constraints that need to be considered when evaluating the intervention. This overview is intended to provide the necessary context for understanding the evaluation framework presented in Chapter 4 and to justify the focus on process evaluation rather than effect evaluation.

Figure 2 – Conceptual overview of the interventions, responsible entities and recipients in the transversal system for eating disorders in Belgium



CEPIA: Centre d'Expertise Poids, Image et Alimentation, GP: general practitioner, GGKJ-SMEA: Geestelijke gezondheid voor kinderen en jongeren-Santé mentale pour les enfants et adolescents (mental health for children and adolescents), AN: anorexia nervosa, BN: bulimia nervosa, BED: binge eating disorder, OSFED: other specified feeding or eating disorder

3.1 Target group of the transversal care model for eating disorders

The interventions defined in the transversal care model apply to beneficiaries who meet the following eligibility criteria.[71, 72] These beneficiaries include children and young people **up to 23 years of age** with an ED who are **not admitted to a hospital** and who have **received a diagnosis from a physician** in accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or the International Classification of Diseases (ICD-11), of **anorexia nervosa (AN)[h], binge eating disorder (BED)[i] or bulimia nervosa (BN)[j].**[8, 11]

In practice, ED care pathways may be initiated up to the age of 23 years and 364 days, meaning that some patients may reach the age of 24 during follow-up.

The ambulatory part-time treatment programme in the ED reference centres (described in section 3.7) also applies to patients admitted to a hospital because of an ED and to those diagnosed with Other Specified Feeding or Eating Disorders (OSFED).[k]

While the interventions are designed for this broader population of children and young people (up to 24 years of age), the evaluation will specifically focus on adolescents and young adults aged 10-24 years. This decision is based on preliminary implementation data of the ED care pathway indicating that the majority of participants fall within this age range (see section 3.3.1.6). Throughout, this protocol, “children and young people” refers to the overall target population of the transversal care model, whereas “adolescents and young adults” is used when describing the target population for the process evaluation detailed within this protocol.

3.2 Intervention A: training programme

3.2.1 Intervention design and roll-out

3.2.1.1 Scope and implementation

Since 1 September 2022, a training programme (intervention A) has been developed for three groups of primary care professionals: **(i) dietitians, (ii) psychologists or educational therapists providing primary psychological care for mild to moderate problems, and (iii) GPs**. Formally, intervention A was only accessible to dietitians, psychologists, or educational therapists who have adhered to the national agreement (geconventioneerd-conventionné).[l] However, according to the organising bodies (i.e. Eetexpert and Centre d'Expertise francophone sur le Poids, l'Image du corps et l'Alimentation [CEPIA]), participation has not been limited in practice to this target group. [m] Professionals who have not adhered to the RIZIV-INAMI agreements, as well as other professional groups (e.g. nurses or psychiatrists) have also enrolled in intervention A.

Intervention A has been implemented through different partnerships over time. During the 2022-2023 period, the programme was organised by Eetexpert for Flanders and Dutch speaking healthcare

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h ICD-11: 6B80; SNOMED CT: 56882008

i ICD-11: 6B82; SNOMED CT: 439960005

j ICD-11: 6B81; SNOMED CT: 78004001

k ICD-11: 6B8Y

l Healthcare providers who have adhered to the national agreement must follow the negotiated fees and, in return, receive certain benefits.

m Eetexpert and CEPIA are the Flemish and French-speaking Belgian expertise centres on eating, weight, and body image issues. They support prevention, early intervention, and treatment through evidence-based information, professional training, tools, and collaboration among healthcare providers.

providers in Brussels, and by the Université Libre de Bruxelles (ULB) for French-speaking healthcare providers. During the 2024-2025 period, the French-speaking programme was transferred to CEPIA, while Eetexpert continued to coordinate the programme in Flanders and for Dutch-speaking providers in Brussels. Eetexpert had already been delivering similar training prior to the agreement, whereas the French-speaking programme was further developed within the framework of the RIZIV-INAMI agreement.

For both programmes (i.e. Eetexpert and CEPIA), the structure of the training is similar and consists of five self-study e-learning modules, an in-person integration day, and an online case discussion session. Although the programmes are coordinated at the national level, each knowledge centre was allowed to define its own priorities and focus areas. Both knowledge centres record the names and email addresses of participants, but do not collect their RIZIV-INAMI registration numbers.

3.2.1.2 Objectives

Table 3 provides an overview of the primary and secondary objectives of intervention A.

Table 3 – Primary and secondary objectives for the training programme (intervention A)

Primary objective	• **Strengthen healthcare providers' knowledge of EDs**, enabling early identification and appropriate referral
Secondary objectives	• **Enable and encourage healthcare providers to initiate early intervention** • **Reduce the need for (full-time) residential admissions** through timely detection and outpatient care • **Prevent (re)admissions** by supporting continuity of care at the outpatient level • Contribute to overall **healthcare cost savings**

3.2.1.3 Financial structure and budget allocation

The organisation and financing of intervention A have evolved considerably since its introduction in 2022. Four distinct phases can be identified.

PERIOD 1: 1 NOVEMBER 2022 TO 31 DECEMBER 2023

Under an agreement with RIZIV-INAMI, Eetexpert was responsible for the development and delivery of training on EDs for Dutch speaking clinical psychologists, educational therapists, and dietitians.

The programme consisted of two components:

- Development of training materials (including translation and adaptation of content);
- Delivery of the training programme, including webinars and training sessions for healthcare professionals.

A total budget of €25 500 was allocated:

- €16 000 for the development of training materials
- €9 500 for the organisation and delivery of training activities

PERIOD 2: 1 JANUARY 2024 TO 31 MARCH 2025

A new agreement entrusted both Eetexpert and CEPIA with the development and delivery of the intervention A.

The target audience was expanded and included: contracted healthcare providers participating in the ED agreement, GGKJ-SMEA network staff and coordinators (Box 4), dietitians, MAST-EMAS teams, GPs, clinical psychologists and educational therapists.

Although specific professional groups were prioritised, the ambition was to disseminate the training as widely as possible among primary care professionals.

The allocated budget amounted to €32 700 for Eetexpert and €35 937 for CEPIA.

This phase marked the transition towards a coordinated bilingual programme delivered through separate Dutch- and French-speaking expertise centres.

Box 4 – GGKJ-SMEA networks

In March 2015, the Belgian Interministerial Conference (IMC-CIM) approved a national guide outlining an integrated mental health policy for children and young people aged 0 to 24 years.[1] This policy takes a comprehensive, life-course approach to care, covering the entire continuum from mental health promotion and prevention to primary care, outpatient services, and highly specialised residential treatment. A central principle of the policy is strong integration and collaboration across mental health care, general health care, and social services.

To support the implementation of this policy, 11 regional networks working in the field of children's and young people's mental health (also known as GGKJ-SMEA networks) were established, corresponding to provincial boundaries and the Brussels-Capital Region (Figure 3). These regional networks bring together all relevant actors and are designed to provide timely, continuous, and coordinated responses to the needs of children, young people, and their families.

Within these networks, severally federal funded programmes have been developed, including:

- **Crisis and long-term care programmes:** which combine mobile support, short-term residential care, and case management for non-life-threatening crises;
- **Intersectoral consultation, liaison, and learning networks:** aimed at strengthening coordination, knowledge exchange, and collaboration across providers and target groups;
- **Dual diagnosis modules**: offering tailored care pathways for young people with both intellectual disabilities and mental health problems, including crisis support and time-out options.

In parallel, child and adolescent psychiatric services and forensic units have been reinforced with additional staff to improve continuity of care and enable the development of "bridging functions" to support young people before, during, and after hospital admission. Liaison teams also provide psychiatric expertise within non-psychiatric hospital settings (e.g. paediatrics, emergency departments).

Finally, the GGKJ-SMEA networks are encouraged to develop innovative projects, with particular attention to young people in transition up to age 24. They also play a key role in expanding access to primary mental health care for children and young people.

Figure 3 – Map of GGKJ-SMEA networks in Belgium



PERIOD 3: 1 JANUARY 2025 TO 30 SEPTEMBER 2025 (BRIDGING PERIOD)

To ensure continuity of the intervention A pending a new organisational model, a temporary ("bridging") agreement was established with Eetexpert and CEPIA. The training offer was restructured into four learning pathways: GPs, specialist psychologists and educational therapists, dietitians working with young people with EDs, and primary care psychologists involved in prevention, early detection, and support of young people with emerging EDs. All programmes followed a hybrid format combining self-study modules, practical exercises, and case discussions.

Although the agreement formally ran until 30 September 2026, funding was only secured until 30 September 2025.

Funding allocated under this bridging arrangement was €16 400 (+ €150 administrative costs) for Eetexpert and €17 968.50 (+ €150 administrative costs) for CEPIA.

PERIOD 4: 1 OCTOBER 2025 TO 31 DECEMBER 2026

Findings from the EPCAP 2.0 evaluation and feedback from stakeholders highlighted the need for additional and more specialised training opportunities for healthcare professionals involved in the agreement.[n] [73, 74]

Because the existing central funding mechanism could not be legally renewed, responsibility for funding training programmes was transferred to the GGKJ-SMEA networks.[75] This responsibility is formally included in the agreement concerning the primary psychological function within the GGKJ-SMEA networks.

This made networks responsible for selecting and financing training programmes; training activities had to comply with public procurement legislation and participants cannot be charged a registration fee. The available budget varies between GGKJ-SMEA networks and depended on factors such as population size and other allocation criteria. The exact budget for training relating to EDs has to be

[n] The EPCAP 2.0 (Evaluation of Primary care Psychology in Belgium) study, conducted by KU Leuven and ULiège, refers to the scientific evaluation of Belgium's RIZIV-INAMI agreement for the primary psychological function. It examined the accessibility, effectiveness, and implementation of the function, and its findings informed the 2024-2026 mental health agreement, including the expansion of patient functions and the strengthening of specialised training provisions.

defined in the annual activity reports, as the GGKJ-SMEA networks are free to decide which modules to allocate their budget to.

To ensure consistency across the country, networks were required to base their training offer on a predefined list of nationally developed modules. Local adaptations beyond this framework were not foreseen.

By 2027, the aim is to return to a centralised organisation of intervention A, managed by the federal government.

3.2.1.4 Reporting

Eetexpert and CEPIA were asked to document their activities related to the training programme (intervention A) in an activity report. Following the transfer of responsibility for organising the training programmes to the GGKJ-SMEA networks, these networks will similarly be required to document their activities in an annual activity report.

3.2.1.5 Expected or already implemented changes

The main changes in the governance, target groups, and funding of intervention A since 2022 are described in section 3.2.1.3. Following several changes in the funding model, the long-term objective is to re-establish a centrally organised training programme under the management of the federal government from 2027 onwards. To this end, the Federal Public Service (FPS) Public Health is currently preparing the tender specifications for the future programme. The procurement procedure is expected to be completed in early 2027. The intention is to collaborate with one or more providers capable of delivering the broadest possible range of the 21 training modules included in the tender specifications, which cover not only EDs but also a wider range of topics related to mental health care in primary care settings.

3.2.1.6 Implementation status

Information on the implementation of intervention A (training programme) is limited to the data requested from Eetexpert and CEPIA for 2024-2025. Comparison and integration of these data are challenging because **both organisations use different registration and reporting systems**. Therefore, this report focuses only on indicators that could be compared across organisations, namely the number of registrations and completed e-learning modules by professional group (Table 4). It should be noted that both organisations have expanded their activities beyond the original basic e-learning programme (e.g. training on multi-family therapy or programmes focused on specific professional groups).

Across both organisations, psychologists and educational therapists represented the largest participant group, whereas participation of GPs was substantially lower (Table 4). Furthermore, completion rates indicate a degree of participant attrition throughout the training trajectory, particularly among GPs.

From September 2025 onwards, responsibility for the provision of intervention A was transferred to the GGKJ networks (section 3.2.1.5). Little information was available on the implementation of these activities by the networks, limiting our ability to assess this phase of the intervention.

Table 4 – Number of registrations and completed e-learnings by professional group and training provider (2024-2025)

	Eetexpert*	CEPIA†
Dietitians		
Registered	81	45
Completed	45	35
Psychologist and educational therapists		
Registered	189	208
Completed	94	94
GPs		
Registered	47	31
Completed	24	5

** For these data, we report only the number of participants registered for and completing the e-learning courses. Eetexpert also reports registrations of participants who have adhered to the national agreement (geconventioneerd-conventionné) or not, although this breakdown is not available for course completions.*

† For these data, we report only final exam enrolments and completions by professional group. CEPIA also offered common modules that were available across all professional groups.

3.2.2 Evaluation constraints

Data protection limitations

In accordance with the European Regulation 2016/679, the General Data Protection Regulation (GDPR), participants in the training programmes did not provide explicit consent for their personal contact details, including their names and contact information, to be shared with third parties for evaluation purposes.[76] As a result, these data cannot be transferred to KCE and participants cannot be contacted for the evaluation. As the participants' RIZIV-INAMI registration numbers are not collected either, it is not possible to identify or contact healthcare professionals through RIZIV-INAMI administrative procedures. Therefore, the evaluation cannot assess the extent to which the objectives of the training programme have been attained.

Methodological implications of decentralised implementation

Since intervention A is currently organised in a **decentralised manner by the GGKJ-SMEA networks**, there is a significant risk of variation in programme content, delivery and implementation strategies across regions. Such fragmentation compromises the standardisation of the intervention and reduces comparability between networks.

From a methodological perspective, this heterogeneity makes it difficult to conduct a reliable and valid evaluation of intervention A at a national level. Differences in the selection of modules, training providers, target groups, and implementation approaches may influence outcomes and hinder the attribution of observed effects to the training programme itself.

In addition, the planned return to a centrally organised training model in 2027 introduces a further challenge for evaluation. Changes in governance, funding mechanisms, training providers, and programme delivery may affect both participation and outcomes, making it difficult to compare results over time and to distinguish the effects of the training content from the effects of changes in implementation arrangements.

Finally, the process evaluation of the transversal care model is required to be completed by the end of 2028. This relatively short timeframe further limits the scope for assessing the impact of the new centrally organised model, as only a limited period will remain between its expected introduction in 2027 and the conclusion of the evaluation.

3.3 Intervention B: ED care pathway

3.3.1 Intervention design and roll-out

3.3.1.1 Scope and implementation

ED CARE PATHWAY

As of the 1 February 2024, children and young people who are **diagnosed by a physician** with an ED (see 3.1), are eligible for a dedicated care pathway. The pathway provides access to free outpatient, interprofessional care tailored to their needs. This means that key elements of treatment are fully reimbursed by the health insurance, including specialised psychological support, dietary counselling, and coordinated care involving different healthcare providers involved in treatment. The pathway is overseen by the physician who establishes the diagnosis, “activates” the care pathway, and develops and monitors an individualised treatment plan. It also supports regular multidisciplinary consultations among the involved healthcare providers to ensure that care is well coordinated, comprehensive, and responsive to the patient's evolving needs.

Intervention B may be “activated” only when specific conditions are met. In addition to the eligibility criteria described in section 3.1, the patient must **require interdisciplinary outpatient treatment**. This treatment must involve the treating physician and involve at least one additional healthcare professional (e.g. a clinical psychologist or educational therapist specialised in EDs, a dietitian specialising in EDs, a paediatrician, psychiatrist, or child and adolescent psychiatrist, or a general practitioner [GP]). A treatment plan must be established and kept in the medical record by the treating physician.

MULTIDISCIPLINARY CONSULTATION

In the context of the preparation of the treatment plan, the treating physician organises a multidisciplinary consultation for the patient concerned. In addition to the treating physician, this consultation must be attended by at least one of the following providers: psychologist/educational therapist specialised in EDs, dietitian specialising in EDs, paediatrician, psychiatrist or child and adolescent psychiatrist, or a GP. This multidisciplinary consultation results in the establishment of the treatment plan and may be organised a second time to evaluate, adjust, or terminate the plan if needed. No more than **two multidisciplinary consultations may be held within a twelve-month period**, one for drawing up the treatment plan and one for its evaluation or adjustment. This limitation applies only to consultations reimbursed under the agreement and does not preclude additional multidisciplinary consultations outside the framework of the agreement when considered necessary by the treating team.

SPECIALISED DIETARY CARE

In addition to the reimbursement for the start-up of the care pathway and for the healthcare providers’ participation in multidisciplinary consultations, patients with EDs are entitled to reimbursement for up to 15 sessions with a dietitian.

Dietitian sessions provide support to individual patients and their parents/legal guardian through individual sessions, either with or without the parents or legal guardian. These sessions may include dietary assessment and diagnosis, dietary treatment such as motivational interventions, medical stabilisation, restoration of healthy eating behaviour, relapse prevention, as well as monitoring and evaluation.

The first two individual sessions have a duration of 60 minutes, with at least 45 minutes of direct patient contact. Subsequent sessions last at least 30 minutes with at least 20 minutes direct patient contact. Sessions take place with the physical presence of the dietitian and the patient (and, where appropriate, the parents or guardian) at a location suited to the patient's situation. With the patient's prior consent and when travel constitutes a significant barrier, sessions may be conducted in the patient's living environment (remote or online). The first individual session must take place within one month of activation of the ED care pathway (intervention B).

Remote sessions are permitted under specific conditions. These sessions may only be organised if the first two sessions took place in person, the patient's physical and mental condition allows remote care, and the patient has provided prior consent. Secure communication methods that meet minimum safety requirements must be used. In addition, remote consultations must be recorded, and their duration documented in the patient file. For the same patient, a maximum of six consecutive individual remote sessions may be reimbursed, after which at least one in-person individual session with the dietitian must take place.

To qualify for reimbursement, the consulted dietitian must meet all of the following conditions. The dietitian must:

- have an agreement with a GGKJ-SMEA network;
- hold a valid visa, be recognised as a dietitian, and have a RIZIV-INAMI registration number;
- have demonstrated clinical experience in dietary care for EDs, as documented in their portfolio;
- have completed the training course on the functioning of mental health networks;
- participate in peer review or supervision with other dietitians or other providers within the network;
- be employed or self-employed;
- maintain an individual patient file for each beneficiary;
- contribute to the development of the treatment plan and participate in the multidisciplinary consultations.

SPECIALISED PSYCHOLOGICAL CARE

Children and young people with an ED can also access primary psychological care through the GGKJ-SMEA networks. This primary psychological care is **defined in the RIZIV-INAMI agreement concerning the primary psychological function**. Although this agreement itself falls outside the scope of the current evaluation study protocol, we provide the reader with a summary in Box 5.[75]

Box 5 – Primary psychological function for children and young people

The RIZIV-INAMI agreement on the primary psychological function within GGKJ-SMEA networks covers psychological care for children, young people, and adults.[75] This information box, however, focuses only on the care and reimbursement arrangements for children and young people.

This agreement aims to strengthen resilience and self-care, and, when necessary, provide short-term treatment for mild to moderate psychological difficulties. Three types of reimbursed support are available:

- **Function 1: community-based group sessions**

  Group sessions aimed at improving resilience and self-care. No limit on the number of sessions.

- **Function 2: primary psychological support**

Short-term, low-intensity support to maintain or restore mental wellbeing. Up to 10 individual sessions are reimbursed for children and young people; group sessions are unlimited.

- **Function 3: primary psychological treatment**

  Short-term treatment for mild to moderate problems when primary psychological support is insufficient. On average 10 individual sessions are reimbursed (with a maximum of 20 sessions); group sessions are unlimited.[o]

A one-off trajectory fee may be charged at the end of the treatment to cover multidisciplinary coordination activities. This fee is €69.35 for a completed trajectory with a single provider (minimum three sessions) or €34.68 per provider when the patient is referred between psychologists or educational therapists (minimum two sessions with each provider). The fee is reimbursable only once per 12-month period.

All sessions are free of charge for individuals up to 24 years old. Care must be provided by a clinical psychologist or educational therapist affiliated with a GGKJ-SMEA network. Community-based group sessions and primary psychological support are directly accessible without referral. Access to primary psychological treatment requires an initial functional assessment conducted by the registered psychologist or educational therapist.

3.3.1.2 Objectives

Table 5 provides an overview of the primary and secondary objectives of intervention B.

Table 5 – Primary and secondary objectives for the ED care pathway (intervention B)

Primary objectives	• **Prevent inpatient and residential admission** by ensuring early detection, rapid referral and timely outpatient treatment, thereby maintaining patients in outpatient care for as long as possible. • **Prevent readmission** by providing structured outpatient aftercare following discharge from residential or inpatient treatment
Secondary objectives	• **Reduce healthcare costs** by avoiding prolonged inpatient or residential treatment • **Decrease waiting lists** for full-time residential treatment • **Improve access to care** by reducing waiting times for initial treatment • **Enhance patient satisfaction** by providing care close to home • **Promote faster recovery** through early intervention and treatment at an earlier stage of illness • **Strengthen multidisciplinary collaboration and coordination** in ED care • **Reduce the number of residential admissions and readmissions** by supporting sustained outpatient management

[o] The term “on average” refers to a target mean of 10 individual sessions per patients, calculated across the entire population served. This target is applied at the aggregate level and is monitored through administrative data to ensure sustainable allocation of available resources.

3.3.1.3 Financial structure and budget allocation

BILLING METHOD ED CARE PATHWAY

The care pathway is activated by the treating physician through the invoicing of the pseudo-nomenclature code 401295.[p] This code entitles the treating physician to a flat fee of €106.05.[q] The fee may be granted only once per patient within a 12 month period and may be invoiced by only one healthcare provider.

This flat fee covers the development of collaboration with other healthcare providers, as well as consultation and communication between providers, particularly in the context of the preparation and ongoing monitoring of the treatment plan. It also includes the treating physician's participation in the multidisciplinary consultations. No supplements may be charged in addition to this flat fee.

BILLING METHOD MULTIDISCIPLINARY CONSULTATION

The multidisciplinary consultation may take place in person, online, or in a hybrid format and must have a minimal duration of fifteen minutes. The treating physician's participation is covered by the flat-rate fee (see above). Other participating healthcare providers may bill a fee for their participation (pseudo-nomenclature code 401310, fee: €22.49[q]). Reimbursement for participation in this multidisciplinary consultation cannot be combined with reimbursements for other multidisciplinary consultations for the same patient on the same day, and no supplements may be charged for this service.

The care pathway is terminated when the ED is under control and no further care is required, or when there has been no ED related contact between the patient and any of the involved healthcare providers for a period of six months. If the patient's condition escalates and more specialised care is required, the care pathway is temporarily suspended. Last, the care pathway cannot be started or extended from the age of 24.

BILLING METHOD SPECIALISED DIETARY CARE

Specialised dietary care must be prescribed by the treating physician and is reimbursable only after initial invoicing of pseudo-nomenclature code 401295. A maximum of 15 sessions may be reimbursed per 12-month period. Pseudo-nomenclature code 401332 (60-minute session) may be invoiced a maximum of two times per 12-month period (fee: €56.21 per session[q]). Pseudo-nomenclature code 401354 (30-minute session) may be invoiced a maximum of 13 times per 12-month period (fee: €28.10 per session[q]). No more than two services under pseudo-nomenclature code 401354 may be invoiced per patient per day.

During the ED care pathway (intervention B), no additional dietitian sessions may be charged to the patient, and no supplementary fees are permitted. A joint session involving the patient and their parents or legal guardian is counted as one reimbursable session. Separate sessions with the patient and with the parents or guardian may be organised on the same day.

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[p] A pseudo-nomenclature code is a temporary RIZIV-INAMI reimbursement code used to register and finance healthcare activities or services that are not yet included in the official nomenclature, such as pilot projects or convention-based care programmes.

[q] From 1 January 2025 onwards, this flat fee will be adjusted annually in line with the indexation mechanism based on the smoothed health index, as determined under Article 207bis of the Act on compulsory insurance for medical care and benefits, coordinated on 14 July 1994, unless the National Commission of Physicians and Sickness funds decides otherwise pursuant to Article 207bis, second paragraph, of the same Act.

3.3.1.4 Expected or already implemented changes

MULTIDISCIPLINARY CONSULTATION

From the 1 April 2026 onwards, several parts of intervention B have been revised. Compared with the initial conditions, the requirements have been made more specific. Previously, the multidisciplinary consultation with the treating physician only needed to include at least one other healthcare provider (i.e. clinical psychologist/educational therapist specialised in EDs, dietitian specialising in EDs, a paediatrician, a psychiatrist or child and adolescent psychiatrist, or a GP). It is now mandatory that at least the clinical psychologist/educational therapist and dietitian specialising in EDs participate in the start-up and multidisciplinary consultation. Where relevant, the care team may be further expanded with one additional healthcare provider: a paediatrician, a psychiatrist or child and adolescent psychiatrist, or a GP. In addition, the conditions relating to safety and data sharing of the treatment plan have been defined more explicitly.

SPECIALISED DIETARY CARE

Concerning specialised dietary care, the **maximum number of reimbursed sessions has been increased from 15 to 38 sessions**, corresponding to a total of 20 hours of care. The number of 60-minute sessions remains limited to two, while the number of 30-minute sessions has increased from 13 to 36. Furthermore, a new pseudo-nomenclature code (401774, corresponding to a fee of €72,90[q]) has been introduced for a treatment allowance per beneficiary.[77] This allowance covers costs for the dietitian related to multidisciplinary collaboration with other healthcare providers. Specifically, it includes the organisation of multidisciplinary consultations, communication and reporting to other care and support providers within the framework of the treatment plan, and monitoring of the treatment plan. The treatment allowance may be invoiced only once per beneficiary per 12-month period. Reimbursement is conditional upon the completion of at least three individual dietary care sessions and if two multidisciplinary consultations have taken place. No supplementary fees may be charged in addition to this allowance. Finally, the conditions governing remote consultations have been revised. A maximum of six consecutive individual remote sessions is permitted for the same patient. After this limit is reached, at least one in-person individual session with the dietitian must be completed and certified before any further remote sessions may be reimbursed.

3.3.1.5 Reporting

No additional reporting is required beyond registration of the pseudo-nomenclature codes and registration requirements in the patient record.

3.3.1.6 Implementation status

Table 6 presents the number of registered pseudo-nomenclature codes within the ED care pathways in 2025, by sex and age group. The registered codes include the annual physician follow-up fee, participation in multidisciplinary consultations, and individual dietetic sessions of 30 and 60 minutes.

A total of 1 777 ED care pathways were initiated in 2025, based on registrations of the annual physician follow-up fee and used as a proxy for the number of patients in the ED care pathway. The largest number of patients were observed in the 15-19 years age group (n = 1 010), followed by the 20-24 years (n = 411) and 10-14 years (n = 327) age groups.

Activity was concentrated among adolescents and young adults, particularly in the 15-19 years age group, which accounted for 4 698 registered activities, followed by the 20-24 years (1 786 activities) and 10-14 years (1 416 activities) age groups. In contrast, relatively few activities were registered among children age 0-4 years (7 activities) and 5-9 years (59 activities).

Across all age groups, the majority of registered activities concerned female service users (7 443 activities, 93.4%), while 523 activities (6.6%) were registered for male patients. Individual dietetic interventions represented the largest category of registered activities.

Table 6 – Implementation uptake ED care pathway (intervention B), by sex and age group (2025)

Sex	Age group	Annual physician follow-up fee n (%)	Multidisciplinary consultation participation	Individual dietetic session (60 min)	Individual dietetic intervention or evaluation (30min)
		n (%)	n (%)	n (%)	n (%)
Female	0-4 years	3 (0.2)	1 (0.3)	0 (0.0)	0 (0.0)
	5-9 years	13 (0.7)	3 (0.8)	3 (0.2)	13 (0.3)
	10-14 years	269 (15.1)	72 (18.0)	209 (17.1)	679 (14.9)
	15-19 years	943 (53.1)	219 (54.8)	686 (56.3)	2 627 (57.5)
	20-24 years	381 (21.4)	73 (18.3)	242 (19.9)	1 007 (22.0)
	Total female	1 609 (90.5)	368 (92.0)	1 140 (93.5)	4 326 (94.7)
Male	0-4 years	2 (0.1)	1 (0.3)	0 (0.0)	0 (0.0)
	5-9 years	11 (0.6)	5 (1.3)	4 (0.3)	7 (0.2)
	10-14 years	58 (3.3)	16 (4.0)	23 (1.9)	90 (2.0)
	15-19 years	67 (3.8)	9 (2.3)	36 (3.0)	111 (2.4)
	20-24 years	30 (1.7)	1 (0.3)	16 (1.3)	36 (0.8)
	Total male	168 (9.5)	32 (8.0)	79 (6.5)	244 (5.3)
Total	0-4 years	5 (0.3)	2 (0.5)	0 (0.0)	0 (0.0)
	5-9 years	24 (1.4)	8 (2.0)	7 (0.6)	20 (0.4)
	10-14 years	327 (18.4)	88 (22.0)	232 (19.0)	769 (16.8)
	15-19 years	1 010 (56.8)	228 (57.0)	722 (59.2)	2 738 (59.9)
	20-24 years	411 (23.1)	74 (18.5)	258 (21.2)	1 043 (22.8)
Overall total		**1 777 (100.0)**	**400 (100.0)**	**1 219 (100.0)**	**4 570 (100.0)**

Source: RIZIV-INAMI[78]

3.3.2 Evaluation constraints

Methodological implications of changes in content and dose

As described in section 3.3.1.4, intervention B (ED care pathway) has undergone several important revisions since its introduction. Most notably, the requirements for multidisciplinary collaboration have been clarified and strengthened. In addition to the treating physician, both a clinical psychologist or educational therapist and a dietitian with expertise in EDs are now mandatory to participate in the initial and follow-up multidisciplinary consultations. Furthermore, reimbursement of specialised dietary care has been substantially expanded, increasing from 15 to 38 covered sessions.

These changes have important implications for any evaluation of the ED care pathway's effectiveness. Because intervention B has changed substantially since its introduction, the intervention being delivered is no longer consistent over time. The strengthened requirements for multidisciplinary

involvement and the considerable expansion of reimbursed dietary care have altered both the content and intensity of treatment. As a result, outcomes observed across different periods cannot be attributed to a single, stable intervention. In addition, the absence of baseline measurements (e.g. waiting lists for residential treatment, costs, etc.) prior to the ED care pathway's introduction, as well as the absence of a control group, further limits the possibility of conducting a robust effect evaluation. Taken together, the evolving nature of the care pathway and the lack of pre-intervention data make a valid and reliable assessment of programme effectiveness difficult, if not impossible.

3.4 Intervention C: multidisciplinary outpatient support teams GGKJ-SMEA

3.4.1 Intervention design and roll-out

3.4.1.1 Scope and implementation

The multidisciplinary outpatient support teams (MAST GGKJ-EMAS SMEA) provide **expertise-based support to outpatient care providers but do not deliver direct patient care** (unless in exceptional cases). Their role is defined within the RIZIV-INAMI agreements, which outline a range of tasks without specifying minimum mandatory activities for each team. Accordingly, teams support outpatient care providers through case-based consultation, which may take place via remote contact, in-person consultation with the provider, or, in exceptional cases, a single patient contact.

Case support activities consist of evaluating the clinical situation and providing advice and support regarding medical, psychological, or dietary treatment. In addition, the teams can assist outpatient providers managing complex care pathways, map available ED care and identify gaps and discontinuities in care within the GGKJ-SMEA network's area of operation. The teams may also contribute to training activities and facilitate the exchange of expertise with outpatient providers. When the team determines that a request cannot be adequately addressed within its remit, it refers the outpatient provider to more specialised care.

Team composition

Each multidisciplinary outpatient support team consists of the following professionals, all of whom must demonstrate their relevant skills and experience in EDs through their portfolio: (i) up to two clinical psychologists or educational therapists; (ii) one physician specialising in psychiatry or child and adolescent psychiatry; (iii) one physician specialising in internal medicine, paediatrics, or general practice; and (iv) one dietitian.

Additional conditions

The outpatient support team must be accessible by telephone or online via a central hotline from Monday to Friday. The team holds meetings at least once per week. Members of the supra-regional multidisciplinary outpatient support teams (see section 3.6) may also be involved when appropriate, and treating healthcare providers may be invited to participate in discussions concerning their patients. A written report is drawn up of each meeting, including a list of participants and the conclusions drawn for each case discussed. Relevant sections of the report are shared with the participants involved, limited to their own cases.

3.4.1.2 Objectives

Table 7 provides an overview of the primary and secondary objectives of multidisciplinary outpatient support teams.

Table 7 – Primary and secondary objectives for the multidisciplinary outpatient support teams (intervention C)

Primary objectives	• **Support ambulatory and community-based care providers** in early detection, assessment, and management of EDs, enabling them to recognise early signs and guide patients toward the most appropriate level of care, thereby preventing unnecessary escalation to hospitalisation • **Facilitate appropriate care orientation and coordination across care levels,** including support in referral decisions, step-up to hospitalisation when needed, and step-down back to ambulatory care, ensuring continuity of care and preventing admissions
Secondary objectives	• **Reduce unnecessary or prolonged hospitalisations** by maintaining patients in ambulatory settings whenever clinically appropriate • **Optimise patient flow across the care continuum,** including reducing waiting times for specialised residential or hospital care • **Strengthen competencies of ambulatory care providers** through case consultation, training, and knowledge-sharing • **Enhance collaboration and information exchange** between ambulatory providers, local hospitals, and specialised centres • **Reduce reliance on full-time residential admissions** by promoting effective outpatient management and early intervention • **Support timely and adequate assessment** to facilitate appropriate and rapid care decisions

3.4.1.3 Financial structure and budget allocation

BUDGET ALLOCATION

The financing model for the multidisciplinary outpatient support teams is aligned within the financial structure used for Article 56 projects under the Act on compulsory insurance for medical care and benefits.[r] For the execution of the multidisciplinary outpatient support teams, the GGKJ-SMEA network is allocated a maximum annual budget of €248 591.21 (VAT included). This budget covers both personnel and operating costs. Personnel funding includes:

- 1 full-time equivalent (FTE) clinical psychologist or educational therapist (maximum two persons)
- 0.25 FTE physician specialised in psychiatry or child and adolescent psychiatry (maximum one person)
- 0.25 FTE physician specialised in internal medicine, paediatrics, or general practice (maximum one person)
- 0.25 FTE dietitian (maximum one person)

Operating costs account for 10% of the total budget and relate to the purchase of materials and services used in the daily operation of the multidisciplinary outpatient support team (e.g. accommodation, ICT, transport).

Starting from 1 January 2025, the budget is indexed annually in line with the indexation mechanism based on the smoothed health index.

[r] Article 56 projects are pilot initiatives financed by the Belgian compulsory health insurance system, allowing innovative health care programmes to be tested under specific funding arrangements outside standard reimbursement mechanisms.

BILLING METHOD

No fees may be charged for consultations by multidisciplinary outpatient support teams.

3.4.1.4 Expected or already implemented changes

At the time this evaluation study protocol was drafted, no changes had been made to the arrangements for the multidisciplinary outpatient support teams, and none are currently planned.

3.4.1.5 Reporting

The GGKJ-SMEA networks are required to prepare and submit an annual activity report to RIZIV-INAMI by 30 April of the year following the reporting year (year x+1), with an exception until 31 May for the current reporting cycle (i.e. 2026). This report documents and evaluates how their tasks have been implemented over the year. For the multidisciplinary outpatient support teams, the report must include at least the following information:

- Number of care requests received;
- Referrer (i.e. the person or service to whom advice or support was provided);
- Number of advice or support interventions provided;
- Outcome of each care request;
- Number of contacts per care request;
- Patient characteristics (type of ED, age, gender, etc.)

To support consistent reporting, a structured template (approved by the Insurance Committee) is provided to the GGKJ-SMEA networks. The template for 2025 has been slightly revised compared to the 2024 version. The 2025 template is included in Appendix 2.1.

3.4.1.6 Implementation status

Based on preliminary analysis of the information available in the annual activity reports, there appears to be variation in the level of activity and implementation of the GGKJ-SMEA multidisciplinary outpatient support teams across networks (Table 8). Differences can be observed in the volume of care requests, types of services delivered, patient characteristics, and allocation of network activities.

LIMITATIONS OF THE AVAILABLE DATA IN THE ANNUAL ACTIVITY REPORTS

The interpretation and comparison of activity data across networks should be approached with caution, as reporting practices are highly heterogeneous. Several key indicators are not reported in a standardised manner, which significantly limits the possibility for robust transversal analyses.

For example, age-related information is reported inconsistently across networks. Some networks report only the average age of service users, others provide distributions by year of birth, while some indicate only the predominant age group. Several networks do not report age information at all.

Similarly, information on requesting healthcare providers is often incomplete. While most networks provide an overview of the types of professionals initiating care requests, the underlying numbers per professional category are frequently absent, making it difficult to assess the relative contribution of different referral sources.

Additional methodological challenges arise from differences in reporting formats. Some networks present absolute numbers, whereas others provide percentages. In several cases, the denominator used to calculate these percentages is not specified, which complicates comparisons across networks and limits the interpretability of reported figures.

CARE REQUESTS AND SERVICE DELIVERY

The support teams reported an estimated total of approximately 1 665 care requests during 2025, with the number of requests per team ranging from 77 to 246 cases, suggesting variation in uptake and caseloads across networks. The proportion of care requests that resulted in the provision of advice also varied substantially, ranging from 1.3% to 100%. Likewise, the reported average number of contacts per care request ranged from approximately 1.4 to 5.5 contacts.

These differences may reflect, among others, variations in network maturity, local implementation strategies, referral pathways, resource availability, and/or differences in reporting practices. However, the available data do not allow these factors to be examined systematically.

PATIENT CHARACTERISTICS

Where demographic information was available, the reported population consisted predominantly of female patients, often accounting for more than 80% of cases. Across networks, AN was the most frequently reported ED for which a care request was initiated. However, diagnostic profiles differed considerably between networks, and several networks reported relatively large proportions of cases classified as “not specified” or “unknown”, further limiting direct comparisons.

REFERRAL SOURCES

Available data suggest that outpatient psychologists and GPs were among the most common sources of care requests. Other referral sources included parents and patients themselves, dietitians, paediatricians, youth care services, hospitals, and other healthcare or social care professionals. The relative contribution of these referral sources varied across networks, potentially reflecting local care structures and collaboration practices. However, as noted above, the absence of consistent quantitative reporting on requesting healthcare provider types limits a more detailed analysis.

ALLOCATION OF SUPPORT TEAM ACTIVITIES

Across networks, the main areas of activity included networking and outreach, training and capacity-building activities, and care service mapping. The proportion of time allocated to each of these activities varied considerably between support teams, suggesting important differences in local priorities, stages of network development, and organisational approaches.

Overall, the available activity reports provide basic insight into these GGKJ-SMEA multidisciplinary outpatient support teams. However, the substantial variability in reporting practices highlights the need for a more standardised reporting template to facilitate meaningful comparisons across networks and support future evaluation efforts.

Table 8 – Preliminary comparison of reported activity indicators across multidisciplinary outpatient support teams in 2025

	NET01	NET02	NET03	NET04	NET05	NET06	NET07	NET08	NET09	NET10	NET11
Care requests (n)	116	156	170	93	153	212	± 150	133	77	246	159
Advice issued (n)	76	2	76	93	116	107	89	121	74	76	NR
(%)	(62.5)	(1.3)	(44.7)	(100.0)	(75.8)	(50.5)	(59.3)	(91.0)	(96.1)	(30.9)	
In-person consultations (n)	13	0	0	¾ of total care requests	1	4	0	1	0	0	8
Average contacts/request	1.4	2.0	3 to 4	3.0	NR	1.5	4.0	2.0	5.0	5.5	2.0
Sex (%)			NR	NS[s]	NR		NR				
Female	84.5	96.8				85.3		85.0	69.0	20.7	65.4
Male	8.6	2.6				6.6		13.0	6.0	5.7	5.0
Non-binary								2.0			
Not specified	6.9					8.0			25.0	4.1	
Type of ED (%)			NR		NR						
AN	64.7	14.7		75.0		42.5	58.0	45.0	81.0	13.0	30.2
BN	4.3	3.2		15.0		5.2	14.0	3.0	13.0	1.2	5.0
BED	0.9	4.5		5.0		1.9	NS	2.0	0.0	5.3	6.3
ARFID	9.5	1.3				4.7	NS	6.0			0.6
Other ED	12.1	NR				6.1		4.0		6.5	3.8
Other (e.g. obesity)	0.9					2.2		7.0			1.9
Not specified ED	0.0	64.7				22.6		33.0		4.5	17.6
Unknown	7.8	12.2		5.0		14.6		0.0	4.0		
Requesting HCP profile (%)			NS	NS	NS		NS				
Psychologist - outpatient	28.5	30.8				18.9		38.0	39.0	7.3	22.0

[s] The reported sex ratio is 1 boy to 8-9 girls.

	NET01	NET02	NET03	NET04	NET05	NET06	NET07	NET08	NET09	NET10	NET11
Dietitian - outpatient	8.6	21.8				7.6		7.0	3.9	4.1	5.0
Psychiatrist	5.2	1.3				2.8		2.0	2.6	0.4	3.1
GP	17.2	14.1				18.9		32.0	37.7	8.1	11.3[t]
Paediatrician	7.8	1.3				0.9		2.0	7.8		
CCG - SSM	3.5					6.1					
CLB - PMS	0.9					3.3					4.4
General hospital	3.5					4.7				0.4	
University hospital	3.5										
Psychiatric hospital						4.7					
Parent/patient	13.8	21.8				17.0				6.1	
Youth care						1.9					34.0
Mobile team						2.8				0.4	2.5
Other	7.8	2.6				10.4				4.1	16.4
Time spent on (%)											
Care service mapping	10.0	40.0	20.0	15.0	20.0	10.0	20.0	NR	25.0	Max 5.00	20.0
Networking and outreach	35.0	10.0	30.0	25.0	50.0	25.0	NR	20.0	45.0-50.0	50.0	50.0
Training activities	15.0	10.0	40.0	NR	15.0	15.0	20.0	20.0	45.0	25.0	30.0

To preserve anonymity, each participating GGKJ-SMEA network was randomly assigned a unique pseudonym (NET01 to NET11).
ED: eating disorder, AN: anorexia nervosa, BN: bulimia nervosa, BED: binge eating disorder, ARFID: Avoidant/restrictive food intake disorder, HCP: healthcare provider, CCG-SSM: Centra voor Geestelijke Gezondheidszorg-Services de Santé Mentale, CLB-PMS: Centrum voor Leerlingenbegeleiding -Centres Psycho-Médico-Sociaux, NR: data not reported in the annual activity report, NS: not specified (mentioned, but no exact numbers)
Source: Annual activity reports submitted by GGKJ-SMEA networks (2025)

[t] GPs and paediatricians are reported together.

3.4.2 Evaluation constraints

BETWEEN-NETWORK HETEROGENEITY IN SERVICE DELIVERY

A limitation for evaluating the implementation of multidisciplinary outpatient support teams across different GGKJ-SMEA networks is that the RIZIV-INAMI agreements define the teams' mandate in broad terms. As a result, networks may operationalise the mandate differently depending on local priorities, available expertise, resources, and existing care structures. This can lead to substantial heterogeneity in how teams function, the types of support they provide, and the extent to which activities are documented. Consequently, comparisons across networks may be difficult, as observed differences may reflect variation in interpretation and implementation of the mandate rather than true differences in effectiveness or quality of care.

3.5 Intervention D: ambulatory part-time treatment programme GGKJ-SMEA

3.5.1 Intervention design and roll-out

3.5.1.1 Scope and implementation

The ambulatory part-time treatment function is provided by a hospital that is a partner within the GGKJ-SMEA network. Eligibility for ambulatory part-time treatment is assessed by the hospital based on evidence-based guidelines, in consultation with the treating care team and in accordance with an individualised treatment plan. The ambulatory part-time treatment programme is tailored to the patient's needs and includes activities that help children or young people develop healthy eating skills, improve self-perception and body image, regulate emotions, manage time and strengthen social relationships. The treatment team may alternate between part-time treatment for the patient and part-time treatment involving the family through **multi-family therapy (MFT)**, delivered in homogeneous (sub)groups.

CRITERIA FOR THE AMBULATORY PART-TIME TREATMENT PROGRAMME

The part-time treatment programme should be offered on a daily basis for at **least five half-days per week and includes a minimum of four patients each day**. In addition, the patient's family (parents or siblings) can participate in an MFT programme. The part-time treatment programme is complementary to the outpatient treatment programme or to the patient's (semi-)residential treatment. Patients may participate in the programme for between one and five half-days per week. The programme should be grounded on evidence-based guidelines. The hospital should provide details of the therapeutic procedures and care modules offered and submit them to RIZIV-INAMI for evaluation. Furthermore, the hospital or GGKJ-SMEA network should present its vision and therapeutic approach on its website, ensuring transparency for both referrers and patients.

MULTI-FAMILY THERAPY

As part of the ambulatory part-time treatment programme, the hospital offers an MFT programme that combines short-term family group sessions with outpatient individual therapy, individual family therapy, and/or semi-residential treatment. The hospital organises four MFT groups annually, each comprising a minimum of five families. Across these groups, at least 30 MFT sessions are conducted per year. The number of sessions per group varies according to the protocol used, with each session lasting a minimum of two hours. The programme is delivered by a clinical psychologist or educational therapist specialising in EDs, together with a family therapist who specialises in MFT for patients with EDs. Both professionals demonstrate their expertise and experience through their professional portfolios, and the MFT programme is grounded in evidence-based guidelines.

TEAM COMPOSITION

To provide this ambulatory part-time treatment programme, the hospital in the GGKJ-SMEA network has access to an additional 2 FTE beyond its standard staffing resources, of which at least 0.5 FTE clinical psychologist specialising in EDs (maximum 1 person), 0.5 FTE family therapist specialising in MFT for EDs (maximum 1 person), and 1 FTE of choice (filled by a maximum of 2 persons). All these professionals must demonstrate their relevant skills and experience in EDs through their portfolio.

3.5.1.2 Objectives

Table 9 provides an overview of the primary and secondary objectives of the ambulatory part-time treatment programme.

Table 9 – Primary and secondary objectives for the ambulatory part-time treatment programme (intervention D)

Primary objectives	• **Provide intermediate level of care** to prevent admission to full-time residential treatment • **Support step-down care** from residential treatment to lower levels of care, reducing the risk of readmission • **Enable seamless transitions** between levels of care, allowing treatment intensity to be adjusted to the patient's needs and the severity of the ED
Secondary objectives	• **Improve continuity of care** by offering a flexible treatment programme to scale care up or down • **Enhance access to appropriate care** through timely admission to part-time treatment • **Reduce reliance on full-time residential treatment** • **Improve patient outcomes** by matching treatment intensity to individual needs over the course of the illness • **Increase patient and family satisfaction** by providing personalised and adaptable care • **Reduce healthcare costs** by preventing prolonged or repeated admissions

3.5.1.3 Financial structure and budget allocation

Budget allocation

For the ambulatory part-time treatment programme, the GGKJ-SMEA network is allocated an annual budget of €184 664.42 (VAT included), covering the deployment of 2 FTEs and 10% operating costs. From 1 January 2025 onwards, this budget is indexed annually in accordance with the indexation mechanism based on the smoothed health index.

Billing method

For each patient participating in a part-time treatment session, the pseudo-nomenclature codes 401472 (ambulant patients) or 401483 (hospitalised patients) can be billed on a half-day basis for each treatment day. For patients who participate in an MFT session of at least two hours, pseudo-nomenclature codes 401494 (ambulant patients, fee: €0) or 401505 (hospitalised patients, fee: €0) can be charged. When a part-time treatment programme is terminated, pseudo-nomenclature codes 401516 (ambulant patients, fee: €0) or 401520 (hospitalised patients, fee: €0) should be registered.

The pseudo-nomenclature codes 401483, 401505, and 401520 may be accumulated per day with supervision fees for patients who are partially or fully admitted. Pseudo-nomenclature codes 401472, 401494, and 401516 may be accumulated per day with other nomenclature codes.

3.5.1.4 Expected or already implemented changes

At the time this evaluation study protocol was drafted, no changes had been made to the arrangements for the ambulatory part-time treatment programme, and none are currently planned.

3.5.1.5 Reporting

The GGKJ-SMEA networks are required to prepare and submit an annual activity report to RIZIV-INAMI by 30 April of the year following the reporting year (year x+1), with an exception until 31 May for the current reporting cycle (i.e. 2026). This report documents and evaluates how their tasks have been implemented over the year. For the ambulatory part-time treatment programme, the report must include at least a (i) quantitative overview of the number of (half) days of part-time treatment and the number of patients and/or family members present and (ii) a qualitative overview of the part-time treatment offered per week and an evaluation of the intended deliverables per year.

To support consistent reporting, a structured template (approved by the Insurance Committee) is provided to the GGKJ-SMEA networks. The template for 2025 has been slightly revised compared to the 2024 version. The 2025 template is included in Appendix 2.1.

3.5.1.6 Implementation status

Based on a preliminary analysis of the 2025 annual activity reports, four of the eleven GGKJ-SMEA networks had not yet launched their ambulatory part-time treatment programmes (Table 10). Among the programmes that were operational, 50 patients were enrolled in these programmes in 2025. At centre level, enrolment ranged from 3 to 14 patients. Taken together, these findings suggest that the majority of GGKJ-SMEA networks were still in an early implementation or start-up phase during the reporting period.

Some networks predominantly combined part-time treatment with partial admission, whereas others mainly integrated part-time treatment combined with ED care pathways (intervention B). The proportion of patients requiring referral to a higher level of care ranged from 0% to 45%, while step-down to a lower level of care was reported between 55% and 100% where data were available. Participation in MFT activities also differed, with networks reporting between 0 and 2 MFT groups per year and between 0 and 22 sessions annually.

LIMITATIONS OF THE AVAILABLE DATA IN THE ANNUAL ACTIVITY REPORTS

Again, the interpretation of these findings should be approached with caution because the quality and completeness of reporting varied considerably across networks. Several indicators were not reported or only partially specified, limiting the comparability of results.

In addition, the available information does not allow for an assessment of whether staffing requirements are being met. Many networks do not provide details on the employment percentages or FTE allocation of staff members involved in the programmes. In some cases, networks merely list the professional profiles represented within the team without reporting the number of personnel or their corresponding FTEs.

Table 10 – Preliminary comparison of reported activity indicators across ambulatory part-time treatment programmes GGKJ-SMEA in 2025

	NET01	NET02	NET03	NET04	NET05	NET06	NET07	NET08	NET09	NET10	NET11
Patients in PT treatment programme (n)	Not yet launched in 2025			14	Not yet launched in 2025	11	4	11	3	Not yet launched in 2025	7
PT + partial admission (%)				0		100	0	100	0		NR
PT + ED care pathway (%)				70		0	60	73	67		43
PT + full-time admission (%)				25		0	40	0	33		14
Referral to higher level of care (%)				5		45	20	45	0		NR
Step-down to lower level of care (%)				NS		55	80	91	100		NR
MFT groups/year (n)				1		1	0	2	1		1
Families in MFT groups/year (n)				9		4	0	10	4		0
MFT sessions/year (n)				4		15	0	22	NR		0

To preserve anonymity, each participating GGKJ-SMEA network was randomly assigned a unique pseudonym (NET01 to NET11).
PT: part-time, ED: eating disorder, MFT: multi-family therapy, NR: data not reported in the annual activity report
Source: Annual activity reports submitted by GGKJ-SMEA networks (2025)

3.5.2 Evaluation constraints

LOW UPTAKE OF AMBULATORY PART-TIME TREATMENT PROGRAMMES

As described in section 3.5.1.6, a low uptake of the ambulatory part-time treatment programmes can be observed. At the time of the writing of this evaluation study protocol, some GGKJ-SMEA networks had only recently initiated these programmes, while others were still in the process of development. As a result, the number of patients enrolled in these programmes remains limited and unevenly distributed across networks.

Persisting low uptake of the treatment programme reduces the available sample size and the robustness of the conclusions. Furthermore, the uneven rollout across networks introduces variability in programme maturity. Patients included in more established programmes may have different experiences compared to those in newly implemented or still-developing programmes. Limited uptake may also introduce selection bias. In the early phases of implementation, programmes may selectively include specific patient groups (e.g. based on severity, motivation, or logistical feasibility) which may not be representative for the broader target population.

BETWEEN-NETWORK HETEROGENEITY IN RECIPIENTS, INTERVENTION DOSE, AND SERVICE DELIVERY

There is a substantial variation in the organisation and delivery of the ambulatory part-time treatment programmes across GGKJ-SMEA networks. Although the RIZIV-INAMI agreement establishes a common framework, centres differ in how eligibility criteria, target populations, and treatment structures are implemented in practice (see Appendix 3.1).

Differences are observed in admission criteria across networks. Some networks restrict eligibility to specific age groups, whereas others apply broader inclusion ranges. In addition, certain networks use additional clinical thresholds, such as BMI cut-offs. Variation is also present in the delivery of care. Hospitals offering the ambulatory part-time treatment programme differ in the frequency, intensity, and duration of these programmes. As a result, patients may be exposed to different levels of treatment intensity and organisational approaches, even within the same formal programme type.

METHODOLOGICAL IMPLICATIONS

This low uptake and heterogeneity have important implications for the interpretation of findings. Differences observed across GGKJ-SMEA networks may be influenced not only by patient characteristics but also by variations in patient selection, treatment exposure, and organisational context.

As a result, comparisons between networks should be interpreted with caution. Similarly, the generalisability of findings to the transversal ED care programme as a whole may be affected by these differences in implementation across settings.

3.6 Intervention E: supra-regional multidisciplinary outpatient support teams

3.6.1 Intervention design and roll-out

3.6.1.1 Scope and implementation

The supra-regional multidisciplinary outpatient support teams (MAST supraregionaal-EMAS suprarégionale), organised at the level of hospitals with a reference function for EDs (see Box 6), provide **expertise-based support to specialised outpatient and residential care providers but do not deliver direct care, except in exceptional cases where intensification of care is necessary**. Their primary role is to support specialised outpatient and residential care providers, as well as the multidisciplinary outpatient support teams (as described in section 3.4) through case-based consultation. Consultation may take place remotely or in person with the treating provider.

Case-based support involves assessment of the clinical situation and provision of advice regarding medical, psychological, or dietary treatment. In addition, the teams support the management of complex care pathways. This applies when current care provided by specialised outpatient care providers, such as clinical psychologists, GPs, or dietitians, or by residential care providers does not result in sufficient progress and upscaling of care is required. The teams may also temporarily intensify care in collaboration with the treating team by offering a consultation to the patient and/or their family. When the supra-regional multidisciplinary outpatient support team determines that it cannot adequately address the request for advice from the outpatient or residential care provider, the patient is referred to more specialised forms of care, including part-time or residential care.

TEAM COMPOSITION

Each supra-regional multidisciplinary outpatient support team consists of the following professionals, all of whom demonstrate relevant skills and experience in EDs through their portfolio: (i) 0.5 FTE clinical psychologist or educational therapist, filled by a maximum of one person; (ii) 0.25 FTE physician specialising in psychiatry or child and adolescent psychiatry, filled by a maximum of one person; (iii) 0.25 FTE physician specialising in internal medicine, paediatrics or a general practice, filled by a maximum of one person; and (iv) 0.25 FTE dietitian, filled by a maximum of 1 person.

ADDITIONAL CONDITIONS

The same conditions apply with regard to the accessibility and team meetings as for the multidisciplinary outpatient support teams described in section 3.4.

The objective is to provide consultation to the patient and/or their family within one week after a request for temporary intensification of care has been submitted by the treating team or the multidisciplinary outpatient support team. Each supra-regional team should collaborate with multiple multidisciplinary outpatient support teams. To ensure nationwide accessibility, formal partnerships must be established among the nine supra-regional multidisciplinary outpatient support teams and the various multidisciplinary outpatient support teams. These collaborations may include regular coordination meetings held at predefined intervals.

3.6.1.2 Objectives

Table 11 provides an overview of the primary and secondary objectives of the supra-regional multidisciplinary outpatient support teams.

Table 11 – Primary and secondary objectives for the supra-regional multidisciplinary outpatient support teams (intervention E)

Primary objectives	• **Maintain patients at the lowest appropriate level of care** as long as possible by supporting outpatient and residential care providers, preventing escalation to tertiary care • **Facilitate step-down from tertiary care to lower levels of care** and prevent readmission to tertiary hospitals by ensuring smooth transitions and continuity of care
Secondary objectives	• **Reduce healthcare costs** by limiting prolonged admissions in tertiary hospitals • **Decrease waiting lists** for full-time residential treatment in tertiary care settings • **Strengthen knowledge and clinical expertise** of local residential care providers through case support • **Enhance collaboration and information exchange** between tertiary and local hospitals • **Reduce the number of full-time residential admissions** in tertiary hospitals • **Enable faster assessment of ED severity** to support timely care decisions

3.6.1.3 Financial structure and budget allocation

Budget allocation

For the execution of the supra-regional multidisciplinary outpatient support teams, the ED reference centre is allocated a maximum annual budget of €198 307.69 (VAT included), covering the deployment of 1.25 FTEs and 10% operating costs. Starting from 1January 2025, the budget is indexed annually in line with the indexation mechanism based on the smoothed health index.

Billing method

No fees may be charged for consultations by the supra-regional teams.

3.6.1.4 Expected or already implemented changes

At the time this evaluation study protocol was drafted, no changes had been made to the arrangements for the supra-regional multidisciplinary outpatient support teams, and none are currently planned.

3.6.1.5 Reporting

The ED reference centres are required to prepare and submit an annual activity report to RIZIV-INAMI by 30 April of the year following the reporting year (year x+1), with an exception until 31 May for the current reporting cycle (i.e. 2026). This report documents and evaluates how their tasks have been implemented over the year. For the supra-regional multidisciplinary outpatient support teams, the report must include at least the following information:

- Number of care requests received;
- Referrer (i.e. the person or service to whom advice or support was provided);
- Number of advice or support interventions provided;
- Outcome of each care request;
- Number of contacts per care request;
- Patient characteristics (type of ED, age, gender, etc.)

To support consistent reporting, a structured template (approved by the Insurance Committee) is provided to the reference centres. The 2025 template is included in Appendix 2.2.

3.6.1.6 Implementation status

Building further on the observations outlined in section 3.4.1.6 regarding the heterogeneous reporting practices in the annual activity reports, the activity indicators reported by the nine ED supra-regional multidisciplinary outpatient support teams should also be interpreted with caution. Although the reports provide a useful overview of activities and service utilisation, substantial differences in definitions, registration methods, and reporting formats limit the comparability of the data across centres. Several teams explicitly noted that the current annual activity report template lacks clearly defined indicators aligned with their core mandate and activities.

The number of care requests handled by the supra-regional multidisciplinary outpatient support teams varied considerably, ranging from 13 to 176 requests during 2025, with a total of 536 requests handled across all teams (Table 12). Similarly, the reported average number of contacts per care request ranged from approximately 1.1 to 4 contacts. However, these figures are not always directly comparable. Some centres report average contacts per request, while others describe the distribution of requests according to the number of contacts or provide only qualitative estimates. Consequently, differences in service intensity should be interpreted with caution.

The number of in-person consultations with service users also varied between centres, ranging from no reported face-to-face consultations to 139 consultations. This variation likely reflects differences in

organisational approaches rather than differences in case complexity alone. According to the narrative descriptions in the activity reports, some supra-regional teams systematically prefer to assess patients directly before providing advice, whereas others primarily support referring professionals through case discussions and indirect consultation. These different working models have a direct impact on the reported number of patient contacts.

Where demographic information was available, service users were predominantly female across centres. Diagnostic information was reported less uniformly, but among centres that provided a diagnostic breakdown, AN was the most frequently reported ED, representing between 41% and 100% of cases.

Most centres reported high levels of responsiveness following requests for intensification of care, with many indicating that patients were seen within one week in nearly all cases. Several teams nevertheless noted that this target cannot always be achieved due to factors beyond their control, such as patient unavailability or the need for additional assessment before initiating care.

An additional observation emerging from the narrative sections of the activity reports concerns the workload associated with requests that fall outside the formal target population or eligibility criteria defined in the RIZIV-INAMI agreement. These contacts are not always systematically registered and reported across centres, suggesting that the reported activity figures may underestimate the actual workload and demand experienced by the teams.

Table 12 – Preliminary comparison of reported activity indicators across supra-regional multidisciplinary outpatient support teams in 2025

	REF01	REF02	REF03	REF04	REF05	REF06	REF07	REF08	REF09
Care requests (n)	13	176	64	39	22	115	54	39	14
In-person consultations (n)	0	139	17	13	20	41	2	36	7
Average contacts/request	1.2	4.0	3.0	2.4	On average 2-3 (max. 20)	2.8	1.1	NR	1.1
Sex (%)		NS							
Female	100.0		79.7	94.9	80.0	88.5	83.0	92.0	93.0
Male	0.0		14.1	5.1	20.0	11.5	17.0	8.0	7.0
Unknown			6.3	0.0	0.0	0.0	0.0	0.0	0.0
Type of ED (%)		NS	NS	NS	NS				
AN	100.0					58.1	85.2	41.0	100.0
BN						24.2	1.9	2.6	0.0
BED						12.9	1.9	NR	0.0
ARFID						1.6	11.1	NR	0.0
Not specified ED						9.7	0.0	NR	0.0
Care requests received via multidisciplinary outpatient support teams GGKJ-SMEA	0	55	2	5	0	0	1	1	2
Seen within 1 week of intensification request (%)	NA	85.0	100.0	100.0	100.0	20.0	100.0	97.0	100.0

To preserve anonymity, each participating ED reference centre was randomly assigned a unique pseudonym (REF01 to REF09).
ED: eating disorder, AN: anorexia nervosa, BN: bulimia nervosa, BED: binge eating disorder, ARFID: Avoidant/restrictive food intake disorder, GGKJ-SMEA: geestelijke gezondheid voor kinderen en jongeren-santé mentale pour les enfants et adolescents, NR: data not reported in the annual activity report, NS: not specified (mentioned, but no exact numbers), NA: not applicable.
Source: Annual activity reports submitted by ED reference centres (2025)

3.6.2 Evaluation constraints

BETWEEN-NETWORK HETEROGENEITY IN SERVICE DELIVERY

As with the multidisciplinary outpatient support teams (see section 3.4.2), implementation may vary considerably across supra-regional multidisciplinary outpatient support teams due to the broad definition of the intervention within the RIZIV-INAMI framework.

3.7 Intervention F: part-time treatment programme in centres with a reference function for EDs

3.7.1 Intervention design and roll-out

3.7.1.1 Scope and implementation

The RIZIV-INAMI agreements use the official term “centres with a reference function for ED”. To improve readability, this protocol will consistently refer to these centres as “ED reference centres”.

The ED reference centres (Box 6) provide a part-time treatment programme for patients who meet specific clinical and age-related criteria: patients with an ED and or their family, provided that the ED has been formally diagnosed by a physician in accordance with the DSM-5 or ICD-11 classification systems. **Eligible diagnoses include AN, BN, BED, and OSFED**. Beneficiaries may present with one or more comorbidities and must be aged 24 years or younger.

The part-time treatment programme is modular and tailored to the needs of each patient. It includes therapeutic activities aimed at improving eating behaviour, self-perception and body image, emotional regulation, time management, interpersonal relationships, and social functioning. Treatment may be offered to the patient alone or together with their family through **intensive multi-family therapy (iMFT)**, with care delivered in homogeneous subgroups adapted to age and clinical profile.

The centre must organise the part-time treatment programme for a minimum of five half-days per week and includes at least four patients each day.

The part-time treatment programme is complementary to the outpatient treatment programme or to the patient’s (semi-)residential treatment. Patients may participate in the programme for between one and five half-days per week. The programme should be grounded on evidence-based guidelines. The hospital should provide details of the therapeutic procedures and care modules offered and submit them to RIZIV-INAMI for evaluation. Furthermore, the hospital or GGKJ-SMEA network should present its vision and therapeutic approach on its website, ensuring transparency for both referrers and patients.

TEAM COMPOSITION

The programme must be staffed by a multidisciplinary team that includes at least 0.5 FTE family therapist specialised in iMFT for EDs and at least 1 FTE healthcare professional of the centre’s choice. These professionals must be able to demonstrate relevant qualifications, training, and work experience in EDs and part-time treatment programmes through their professional portfolio.

Family members, including parents and siblings, may participate in the iMFT component of the programme. The part-time treatment programme must be complementary to the beneficiary’s outpatient care or to any ongoing semi-residential or residential treatment. Participation may range from half a day to five half-days per week, depending on clinical needs and the treatment plan. All care must be delivered in accordance with evidence-based guidelines.

The centre must clearly describe the therapeutic procedures and care modules offered within the part-time treatment programme. This information is submitted to the RIZIV-INAMI as part of the evaluation process, and the centre or network must communicate its vision and therapeutic approach transparently on its website for referrers and patients.

INTENSIVE MULTI-FAMILY THERAPY

As part of the part-time treatment function, the centre must offer an iMFT programme. This programme may be provided as a stand-alone intervention or in combination with other intensive treatments, such as outpatient or semi-residential care, when clinically indicated. Each iMFT group must include at least five families at the start, with a minimum of four groups organised annually and at least thirty sessions per year, each lasting a minimum of two hours. iMFT must be delivered by a clinical psychologist or educational therapist specialising in EDs and a family therapist specialising in iMFT therapy for EDs. Both professionals must demonstrate their expertise through their portfolio, and the programme must be based on evidence-based guidelines.

Box 6 – Centres with a reference function for EDs

Definition

From 1 April 2025 on, the Insurance Committee of the National Institute for Health and Disability Insurance (RIZIV-INAMI) assigned healthcare organisations that can demonstrate expertise in providing highly specialised care for patients with EDs. Depending on the available budget, the number of centres was limited to a maximum of nine.[u] These nine healthcare organisations operate as supra-regional reference centres for EDs. They deliver care based on the latest scientific evidence, carry out scientific research, and actively share knowledge.

The centre must operate as a healthcare facility, such as a psychiatric, general, or university hospital, or as a collaboration of up to three healthcare facilities, at least one of which is a psychiatric hospital. These facilities must have formal cooperation agreements in place for the diagnosis and treatment of patients with EDs. The centre must function as a single, integrated entity that ensures coordinated care and continuity across services.

In addition to residential and outpatient treatment for children and young people with EDs, these supra-regional reference centres also provide part-time treatment for young people with complex care needs. This part-time programme consists of tailored care modules aligned with the individual treatment plan of the young person and, where relevant, their family, including intensive multi-family therapy. Both outpatient and hospitalised patients can participate in this programme.

Furthermore, the supra-regional reference centres support specialised outpatient and residential care providers, as well as MAST-GGKJ teams, through the MAST supra-regional teams affiliated with the ED reference centres.

Team composition, expertise and training requirements

The centre must operate with a multidisciplinary team that has specific expertise in the management of complex ED care. At a minimum, the multidisciplinary team must include the following professionals: (i) a medical specialist in child and adolescent psychiatry, (ii) a paediatrician or an internal medicine specialist (either employed directly or through a formal collaboration with a nearby hospital), a dietitian, a clinical psychologist or educational therapist, a family therapist, and a psychiatric nurse.

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[u] The following facilities are currently assigned as reference centres for EDs. In Brussels, these are Cliniques Universitaires Saint-Luc, in joint collaboration with Epsylon ASBL Clinique La Ramée; Universitair Ziekenhuis Brussel; and Hôpital Erasme, in joint collaboration with Hôpital Universitaire des Enfants Reine Fabiola (HUDERF). In Flanders, the assigned centres are Psychiatrische Kliniek Broeders Alexianen (Tienen); Ziekenhuis aan de Stroom Middelheim, Cadix, Palfijn, Hoge Beuken, Joostens (Antwerp); Universitair Centrum Sint-Jozef (Leuven); and Universitair Ziekenhuis Gent (Ghent). In Wallonia, the assigned centres are Groupe Santé Centre Hospitalier Chrétien (Liege) and Centre Hospitalier Le Domaine (Braine-l'Alleud).

All team members must demonstrate proven skills and experience in the treatment of EDs. This must be supported by their qualifications, training, or professional experience. With the exception of psychiatric nurses, each professional discipline is required to complete at least one ED related training course per year.

Within the multidisciplinary treatment team, at least three healthcare providers must have a minimum of five years of relevant professional experience in the diagnosis and treatment of EDs. These professionals must demonstrate advanced and long-standing expertise and be actively involved in knowledge sharing and/or scientific research. This level of expertise must be documented in their professional portfolio.

The centre must maintain an up-to-date and comprehensive list of all members of the multidisciplinary treatment team. This list must specify each member's role, contractual status, working hours, and weekly schedule. In addition, the centre must keep a record of all ED related training and continuing education activities completed by healthcare providers within the multidisciplinary treatment team.

Treatment options and facilities

The centre must provide a comprehensive range of treatment options and facilities for the diagnosis and treatment of EDs, ensuring continuity of care across different levels of intensity.

The centre must offer specialised outpatient care, including individual consultations and group-based services, as well as residential treatment capacity for children, adolescents, or transitional age patients. Treatment programmes must be organised in homogeneous subgroups to ensure that care is appropriate to the age and clinical profile of the patients. In addition, the centre must provide a highly specialised range of therapeutic interventions that address both the needs of the patient and those of the family.

A structured part-time treatment programme must be available for patients with EDs and their families, including the provision of multi-family therapy. The centre must also ensure access to somatic care, either through its own facilities or through formal collaboration with internal services and/or paediatric departments of a neighbouring hospital. This includes the possibility of treatment with tube feeding and the use of established protocols for the management of somatic complications associated with EDs.

Lastly, the centre must have clear arrangements in place for crisis intervention when acute situations arise. It must also provide adequate infrastructure to support treatment delivery, including sufficient space for group sessions, meeting rooms for multidisciplinary collaboration, a secretarial office, and secure facilities, physical or digital, for maintaining individual patient files accessible to the multidisciplinary treatment team.

Source: RIZIV-INAMI[72]

3.7.1.2 Objectives

Table 13 provides an overview of the primary and secondary objectives of the part-time treatment programme in reference centres.

Table 13 – Primary and secondary objectives for the part-time treatment programme in reference centres (intervention F)

Primary objectives	• **Provide intermediate level of care** to prevent admission to full-time tertiary residential treatment • **Support step-down care** from tertiary treatment to lower levels of care, reducing the risk of readmission • **Enable seamless transitions** between levels of care, allowing treatment intensity to be adjusted to the patient's needs and the severity of the ED
Secondary objectives	• **Improve continuity of care** by offering a flexible treatment programme to scale care up or down • **Enhance access to appropriate care** through timely admission to part-time treatment • **Reduce reliance on full-time residential treatment** in tertiary centres • **Improve patient outcomes** by matching treatment intensity to individual needs over the course of the illness • **Increase patient and family satisfaction** by providing personalised and adaptable care • **Reduce healthcare costs** by preventing prolonged or repeated tertiary admissions

3.7.1.3 Financial structure and budget allocation

Budget allocation

For the part-time treatment programme, the ED reference centre is allocated an annual budget of €184 664.42 (VAT included), covering the deployment of 2 FTEs and 10% operating costs. From 1 January 2025 onwards, this budget is indexed annually in accordance with the indexation mechanism based on the smoothed health index.

Billing method

Each day, the reference centres can register specific pseudo-nomenclature codes for the participation of patients in the part-time treatment programme. For patients attending a half-day part-time treatment session, pseudo-nomenclature codes 401531 (ambulant patients, fee: €0) or 401542 (hospitalised patients, fee: €0) are certified. For patients participating in an iMFT session of at least two hours, pseudo-nomenclature codes 401553 (ambulant patients, fee: €0) or 401564 (hospitalised patients, fee: €0) are certified. When the part-time treatment programme is terminated, pseudo-nomenclature codes 401575 (ambulant patients, fee: €0) or 401586 (hospitalised patients, fee: €0) should be registered.

Certain codes can be combined with other fees or benefits. Pseudo-nomenclature codes 401542, 401564, and 401586 may be accumulated with supervision fees for patients who are partially or fully admitted. Codes 401531, 401553, and 401575 may be combined with other nomenclature codes.

3.7.1.4 Expected or already implemented changes

At the time this evaluation study protocol was drafted, no changes had been made to the arrangements for the part-time treatment programme in the ED reference centres, and none are currently planned.

3.7.1.5 Reporting

The ED reference centres are required to prepare and submit an annual activity report to RIZIV-INAMI by 30 April of the year following the reporting year (year x+1), with an exception until 31 May for the current reporting cycle (i.e. 2026). This report documents and evaluates how their tasks have been implemented over the year. For the part-time treatment programme, the report must include at least a (i) quantitative overview of the number of (half) days of part-time treatment and the number of patients and/or family members present and (ii) a qualitative overview of the part-time treatment offered per week and an evaluation of the intended deliverables per year.

To support consistent reporting, a structured template (approved by the Insurance Committee) is provided to the reference centres. The 2025 template is included in Appendix 2.2.

3.7.1.6 Implementation status

Similar to the other interventions, the annual activity reports demonstrate considerable heterogeneity in the implementation of the ambulatory part-time treatment programmes across ED reference centres, both in terms of programme characteristics and the way activity indicators are reported (see Appendix 3.2).

The number of patients enrolled in these programmes in 2025 ranges from 4 to 43 patients, with a total of 212 patients enrolled across all participating centres (some programmes are only operational since the end of 2025). Family-based activities also differed between centres, with the number of iMFT groups, participating families, and iMFT sessions ranging from very limited activity in some centres to extensive provision in others.

As with the other interventions, assessing and comparing these programmes is complicated by recurring issues of non-uniformity and lack of clarity in the annual activity reports. Centres did not always report indicators in a consistent manner: e.g. some provided exact percentages, others reported ranges (e.g. “95-100%” or “>90%”). In addition, several ED reference centres operate multiple part-time treatment groups that differ in size, target population, and programme characteristics, making comparisons both within and between centres more difficult. The interpretation of the data is further limited by missing information. For example, five of the nine ED reference centres indicated that they were unable to report the percentage of service users enrolled in an ED care pathway (intervention B) because this information was not available for them.

A further limitation concerns inconsistencies between the Dutch- and French-language reporting templates. While the Dutch template requests information on the average duration of the ambulatory part-time treatment programme, this indicator is not included in the French version. Consequently, centres using different language templates are not asked to provide the same information, which undermines standardisation and further limits the comparability of the reported data.

Table 14 – Preliminary comparison of reported activity indicators across ambulatory part-time treatment programmes in ED reference centres in 2025

	REF01	REF02	REF03	REF04	REF05	REF06	REF07	REF08	REF09
Patients in PT treatment programme (n)	16	25	43	14	40	25	4	7	38
PT + partial admission (%)	16.7	30.0	0.0	100.0	NA	0.0	95.0-100.0	0.00	100.0
PT + ED care pathway (%)	NR	80.0	21.0	NR	76.0	NR	NR	57.1	NR
PT + full-time admission (%)	0.0	40.0	79.0	NR	23.0	19.2	NS	42.9	7.9
Referral to higher level of care (%)	50.0	0.0	35.0	17.0	4.0	8.0	NR	NA	18.4
Step-down to lower level of care (%)	NA	70.0	65.0	83.0	96.0	26.9	> 90.0	NA	81.6
iMFT groups/year (n)	6	3-4	1	4	4	1	4	1	4
Families in iMFT groups/year (n)	6	5	31	17	31	8	33	7	18
iMFT sessions/year (n)	2	4	8	40	48	3	77	8	18

To preserve anonymity, each participating ED reference centre was randomly assigned a unique pseudonym (REF01 to REF09).
PT: part-time, ED: eating disorder, iMFT: intensive multi-family therapy, NR: data not reported in the annual activity report, NS: not specified (mentioned, but no exact numbers), NA: not applicable.
Source: Annual activity reports submitted by ED reference centres (2025)

3.7.2 Evaluation constraints

INCLUSION OF PATIENTS WITH OSFED FOR THE PART-TIME TREATMENT PROGRAMMES

A first limitation concerns the inclusion of patients diagnosed OSFED within the part-time treatment programmes offered by ED reference centres. The transversal care model for children and young people with EDs defines AN, BN, and BED as the primary diagnostic groups for inclusion.[71, 72] However, for the part-time treatment programme ED reference centres can additionally include patients with OSFED.

This difference in eligibility criteria introduces heterogeneity in the study population across interventions. OSFED is a clinically heterogenous category encompassing individuals with diverse symptom profiles, severity levels, and functional impairment.[79, 80] As a result, the inclusion of OSFED patients increases variability in clinical presentation within the overall sample.

This variability may complicate the interpretation of aggregated results, as differences in patient-reported experiences may reflect differences in diagnostic composition rather than differences in care delivery or programme effectiveness. In addition, the proportion of OSFED patients may vary between centres depending on local diagnostic practices, expertise and referral patterns, which may lead to systematic differences in case mix across sites. This introduces a potential source of confounding in cross-centre comparisons and in the overall evaluation of the transversal care programme.

BETWEEN-CENTRE HETEROGENEITY IN RECIPIENTS, INTERVENTION DOSE, TREATMENT EXPOSURE AND SERVICE DELIVERY

A second important limitation is the heterogeneity in the organisation and delivery of care across ED reference centres. Although the overarching RIZIV-INAMI agreement for ED established a shared framework, considerable variation exists in how eligibility criteria, target populations, and treatment structures are applied in practice (see Appendix 3.2).

Differences exist in admission criteria across centres. Some centres restrict eligibility to specific age ranges, whereas other include broader age groups. In addition, certain centres apply additional clinical thresholds, such as BMI cut-offs. These differences reflect the historical development of services prior to the establishment of the RIZIV-INAMI agreement in 2024, but results in a non-uniform patient selection across sites. To improve coordination, several ED reference centres have agreed on a complementary distribution of target age groups: ZAS-UKJA and UZ Brussels focus on patients under 15 years of age, while Psychiatrische Kliniek Broeders Alexianen, UPC KU Leuven, and UZ Ghent focus on patients aged 15 years and older.”

Treatment delivery itself is also heterogeneous. Reference centres differ in the frequency, intensity, and duration of the part-time treatment programmes. As a consequence, patients enrolled in different centres may be exposed to meaningfully different doses and organisational models of care, even within the same formal programme configuration.

METHODOLOGICAL IMPLICATIONS

Together, these sources of heterogeneity have important methodological consequences. They limit the comparability of patient experiences across and between ED reference centres. They may also reduce the extent to which findings can be generalised to the overall transversal care programme. Observed differences in outcomes or experiences may therefore reflect variations in patient composition, treatment intensity, or organisational structure rather than true differences in patient characteristics or intervention effects.

3.8 Conclusion

The transversal care model on EDs establishes a publicly funded care programme consisting of **six complementary interventions for children and young people up to 24 years of age diagnosed with AN, BN, or BED**. The programme is designed to facilitate early identification and timely referral, provide accessible multidisciplinary outpatient care close to home, reduce the need for inpatient and residential treatment, and strengthen coordination and continuity of care across healthcare providers.

The interventions under study were implemented in routine practice before this evaluation study protocol was developed, with some already rolled out in 2024. As a result, they were not introduced under controlled research conditions, and no pre-implementation baseline data or comparison groups are available. In addition, the interventions do not consistently target the same patient groups. Most focus on children and young people (up to 24 years) diagnosed with AN, BN, or BED, while one also includes the broader OSFED population (i.e. Intervention F, part-time treatment programme in reference centres).

As shown in Table 15, the interventions also differ in several key implementation dimensions. Variability exists in the content, sequence, dose, target population, mode of delivery, delivering organisations, and funding mechanisms. The training programme (intervention A) and care pathway (intervention B) are particularly characterised by repeated modifications over time, including changes in content, delivery arrangements, funding structures, and target groups. In contrast, variation in recipient populations and modes of delivery is observed across several treatment-oriented interventions. Furthermore, some interventions have evolved since their initial implementation, reflecting adaptations made during routine delivery. While such changes may improve responsiveness to clinical needs, they complicate evaluation by making it difficult to determine which specific version or intensity of an intervention is being assessed and whether observed outcomes can be attributed consistently across sites and over time.

Taken together, **the lack of a common baseline, the absence of comparison groups, and the substantial heterogeneity in intervention design and implementation preclude a methodologically robust effect evaluation**. The variability summarised in Table 15 reduces comparability within intervention types and severely limits the ability to attribute observed outcomes to the interventions themselves. Consequently, no valid conclusions can be drawn regarding the overall effectiveness of the transversal ED care model in Belgium. Therefore, the evaluation described in this study protocol will focus on process outcomes rather than effectiveness outcomes. Particular attention will be paid to identifying barriers and facilitators to implementation, generating lessons that may inform the further optimisation, scale-up or adaptation of these interventions and the transversal care model in general. In addition, the process evaluation will explore stakeholders' perceptions of the interventions' effects, providing insight into perceived benefits, challenges, and added value despite the limitations for formal effect assessment.

Table 15 – Sources of variability in the implementation of the interventions

Dimension of implementation variability	Intervention A Training programme	Intervention B ED care pathway	Intervention C Multidisciplinary outpatient support teams GGKJ-SMEA	Intervention D Ambulatory part-time treatment programme GGKJ-SMEA	Intervention E Supra-regional multidisciplinary outpatient support teams	Intervention F Part-time treatment programme in reference centres
Content	x					
Sequence	x					
Dose	x	x				
Delivering provider/organisation	x	x				
Recipient	x			x		x
Mode of delivery	x	x				x
Funding	x	x				

4 EVALUATION FRAMEWORK

KEY POINTS

- The transversal care model for children and young people with EDs is a **complex intervention**, consisting of six interrelated interventions implemented across multiple care settings and organisational levels.
- Given the absence of pre-implementation baseline data, suitable comparison groups, and the substantial heterogeneity in intervention design and implementation, a robust effect evaluation is not feasible. Therefore, we adopt a **process evaluation** approach based on the Medical Research Council (MRC) framework, focusing on **implementation, mechanisms of change, and context**.
- This evaluation was **commissioned by RIZIV-INAMI** to inform decisions regarding the future of the transversal care model, which ends at the end of 2028.
- The implementation component is structured using the **RE-AIM framework** (Reach, Effectiveness, Adoption, Implementation, and Maintenance), allowing a systematic assessment of intervention uptake, delivery, stakeholder experiences, and sustainability.
- Particular attention is paid to understanding how multidisciplinary collaboration, provider expertise, accessibility of care, family involvement, and support structures contribute to the functioning of the care model and to stakeholders' perceived outcomes.
- Contextual factors at the policy, organisational, professional, and patient level are explicitly considered to explain variation in implementation and identify barriers and facilitators for future optimisation of the transversal care model.

This document presents the protocol for a one-time process evaluation of the transversal care model for children and young people with EDs. This process evaluation seeks to answer the following research question: How and to what extent have the interventions included in the transversal care model for children and young people with EDs been implemented in Belgium, and which factors influence implementation, perceived effectiveness, mechanisms of change, and sustainability?

The evaluation was commissioned by RIZIV-INAMI to inform decisions regarding the future of the care model which currently runs until the end of 2028. Although some data collection tools and reporting structures developed within this protocol may be useful for future monitoring activities, the present document does not constitute a long-term monitoring framework.

4.1 Logic model

The transversal care model for children and young people with EDs comprises multiple interacting interventions implemented across different settings and levels of care. As such, it can be considered a **complex intervention**, in line with the interpretation provided by the Medical Research Council (MRC) on the development and evaluation of complex interventions. Complex interventions are characterised by multiple interdependent components, which interact within dynamic systems and therefore require explicit articulation of how they are expected to produce change.[81]

To make the underlying assumptions and hypothesised pathways of change of the transversal care model more explicit, a logic model was developed. Logic models are widely used in the evaluation of complex interventions as they provide a structured and visual representation of the core elements of an intervention, including its inputs, activities, outputs, and outcomes. In addition, they illustrate the relationships between these components and specify the mechanisms through which change is

expected to occur, as well as the contextual conditions and resources required for implementation. Beyond their descriptive function, logic models serve as an important tool to guide the design of the process evaluation.[82]

Figure 4 presents the conceptual logic model underpinning the transversal care model for children and young people with EDs. The model provides a structured overview of the hypothesised relationships between the inputs, activities, outputs, and anticipated outcomes, while explicitly situating the interventions within the broader healthcare system and the challenges that motivated their development. In particular, it reflects the need to improve early detection of EDs, strengthen outpatient care, and reduce pressure on specialised and inpatient services.

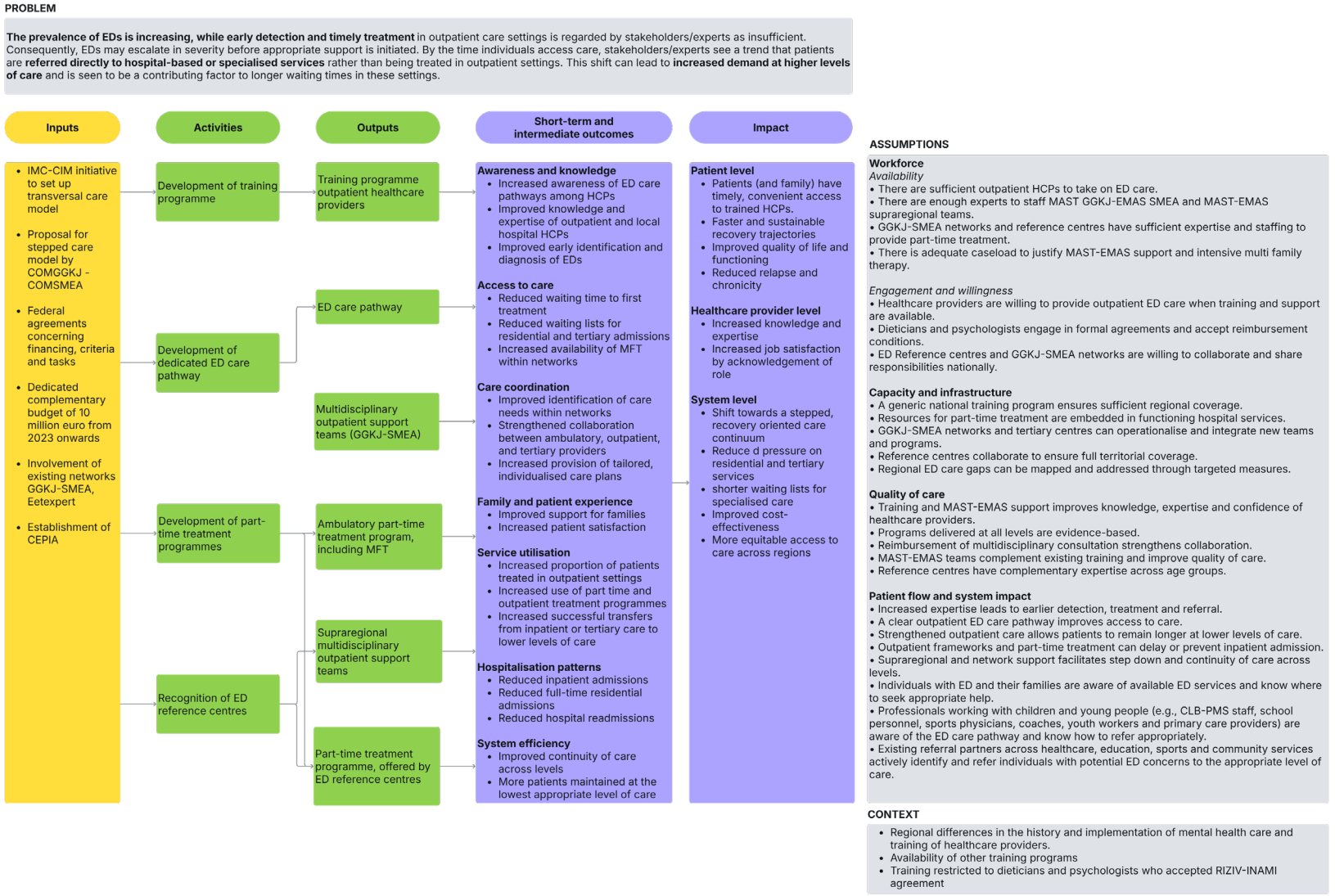
However, it is important to interpret the logic model with appropriate caution. Although the model is presented in a linear format, suggesting a sequential progression from activities to outputs and outcomes, this representation is primarily intended as a heuristic and analytical tool. In practice, complex interventions operate within dynamic systems in which components of the care model interact, influence one another, and evolve over time.[83, 84] Consequently, the different elements of the care model are expected to function simultaneously and iteratively rather than through a strictly linear causal pathway.

The logic model also has some inherent limitations. Given the diversity of stakeholders, settings, and intervention components, the model has been deliberately simplified to enhance readability and usability. As a result, it focuses on the most essential activities, outputs, and outcomes, and does not capture the full complexity of the system in which the interventions are embedded. In particular, it does not explicitly represent all contextual factors, nor the full range of barriers and facilitators that may influence implementation.

It should be noted that the interventions included in the logic model are unlikely to be sufficient on their own to achieve the intended outcomes. Broader contextual factors and complementary interventions, such as other components of the mental health care system (e.g. the primary psychological care function for children and young people), are expected to play a critical role. The logic model should therefore be interpreted as a representation of the core contribution of the transversal care model within a wider system of care, rather than as a comprehensive depiction of all factors influencing outcomes.

Given the scope of the present study, the logic model has primarily been developed to support the process evaluation by clarifying implementation processes, mechanisms of change, and contextual influences. Should future evaluations focus on assessing impact or outcomes, the logic model would need to be further refined and expanded, particularly with regard to the specification of causal pathways, outcome indicators, and measurement assumptions required for robust effect evaluation.

Figure 4 – Logic model of the transversal care model for children and young people with EDs



4.2 Overall methodology

The care model was implemented in routine practice prior to the development of the present evaluation study protocol, with initial roll-out of certain interventions beginning in 2024. As a result, the interventions were not introduced under controlled research conditions, and no pre-implementation baseline data or comparison groups are available. This substantially limits the feasibility of conducting a rigorous effect evaluation and precludes robust causal inference regarding intervention effectiveness. **Given these constraints, and acknowledging the real-world nature of the implementation, the current evaluation focuses on process evaluation.**

Process evaluations are a key component of complex intervention research, providing insights into how and why interventions achieve their outcomes.[85] The MRC has developed a widely used framework for designing and conducting process evaluations alongside trials and other evaluative studies.[85] This framework highlights the importance of going beyond outcome data to understand intervention delivery, underlying mechanisms, and the influence of context. Such understanding is essential for interpreting effectiveness results and for informing future implementation, scale-up, or adaptations of interventions.

The MRC framework identifies three core domains that should be examined within a process evaluation.[85]

1. **Implementation:** this domain focuses on what is delivered and how it is delivered, including aspects such as fidelity, dose, and reach.
2. **Mechanisms of change:** this domain explores how participants engage with the intervention and how these interactions lead to change. It seeks to identify causal pathways through which the intervention produces both anticipated and unexpected outcomes.
3. **Context:** this domain examines external factors that may influence both implementation and outcomes, including organisational, social, and environmental conditions.

Together, these domains provide a comprehensive understanding of how an intervention functions in practice, complementing and enriching outcome evaluations.

The MRC guidance also recommends integrating qualitative and quantitative methods through mixed-methods approaches.[81, 85] This allows researchers to capture both measurable aspects of implementation as well as experiential insights from stakeholders. Importantly, process evaluations should be theory-informed and aligned with the intervention's underlying logic model, enabling the testing of assumptions about causal pathways and the identification of factors that facilitate or hinder effectiveness.

In line with this framework, the present evaluation study protocol adopts a mixed-methods design. This approach combines analysis of administrative databases, annual activity reports, and both quantitative and qualitative data collection. Data will be collected from multiple stakeholder groups, including healthcare providers, operational decision-makers (e.g. mental network coordinators, middle managers, coordinators of ED reference centres), as well as adolescents and young adults with EDs and their families.

4.2.1 Research questions

As outlined at the beginning of this chapter, the overarching question guiding this process evaluation is as follows:

How and to what extent have the interventions included in the transversal care model for children and young people with EDs been implemented in Belgium, and which factors influence implementation, perceived effectiveness, mechanisms of change, and sustainability?

This overarching question is further operationalised into questions relating to (i) implementation, (ii) mechanisms of change, and (iii) context. The specific research questions are listed in Box 7.

Box 7 – Research questions

Implementation (RE-AIM)

- To what extent do the interventions reach their intended target populations, including service users, healthcare providers, GGKJ-SMEA networks and ED reference centres?
- How do service users, parents or legal guardians, healthcare providers and organisations perceive the added value and effectiveness of the interventions?
- To what extent have healthcare providers, GGKJ-SMEA networks, hospitals and ED reference centres adopted the interventions as intended?
- To what extent are the interventions delivered according to their intended design, including their content, intensity, multidisciplinary collaboration and organisational requirements?
- What factors influence the sustainability and long-term integration of the interventions into routine care?

Mechanisms of change

- How does increased provider expertise and training contribute to perceived earlier detection and appropriate referral of EDs?
- How do accessibility and reduced barriers to care influence treatment engagement and adherence?
- How do patient-centred care processes and therapeutic relationships influence perceived quality of care and outcomes?
- How does family involvement contribute to treatment engagement and recovery processes?
- How do provider support structures such as multidisciplinary outpatient support teams influence clinical decision-making and perceived quality of care?

Context

- How do regional and organisational factors influence variability in implementation and accessibility of the interventions?
- How do policy, regulatory and financial factors influence implementation and stakeholder engagement?
- How do characteristics of the target population influence access and engagement in the use of the interventions?
- How does interorganisational collaboration influence continuity and coordination of care?

4.3 Implementation

The implementation evaluation of the different interventions of the transversal care model for children and young people with EDs aims to provide a comprehensive understanding of:

- **how** the interventions are delivered,
- **what** is actually delivered, and
- **how they are experienced** by the key stakeholders, including service users, parents or legal guardians, and healthcare organisations or -providers.

The implementation-domain of the process evaluation will be guided by the RE-AIM framework, which serves as the overarching structure.[86] This framework is widely used in implementation science and has been applied in the process evaluation of complex interventions.[87-89] It comprises five key

dimensions: reach, effectiveness, adoption, implementation, and maintenance. Together, these dimensions enable a systematic assessment of factors influencing intervention performance at both the individual and organisational level. Not all RE-AIM dimensions need to be assessed in every evaluation; rather, the framework encourages researchers to select those dimensions that are most relevant to the study objectives, context, stakeholders, and stage of research.[86] However, for the present process evaluation, all five dimensions will be considered to provide a comprehensive understanding of intervention impact, implementation processes, contextual influences, and the feasibility of ongoing monitoring. An overview of the definitions and pragmatic priorities for each dimension is provided in Table 16.

Table 16 – RE-AIM dimensions and their definitions

Dimensions	Definition	Key pragmatic priorities
Reach	The absolute number, proportion, and representativeness of eligible individuals who are willing to participate in a given initiative, intervention, or programme.	**Who** is intended to benefit and who actually participates or is exposed to the program or policy?
Effectiveness	The impact of an intervention on important outcomes, including potential negative effects, quality of life, and economic outcomes.	**What** is the most important benefit you are trying to achieve and what is the likelihood of negative outcomes?
Adoption	The absolute number, proportion, and representativeness of settings and intervention agents (people who deliver the program) who are willing to initiate a programme.	**Where** is the programme or policy applied? **Who** applied it?
Implementation	**Organisational** Implementation refers to how closely those delivering the intervention adhere to the protocol, including whether it is delivered consistently as intended, as well as the time and cost involved. **Individual** At the individual level, implementation refers to how clients use the intervention strategies.	**How** consistently is the programme or policy delivered? **How** will (was) it (be) adapted? **How** much will (did) it cost? **Why** will (did) the results come about?
Maintenance	**Organisational** The extent to which a programme or policy becomes integrated into routine organisational practices and policies. In addition, maintenance includes the proportion and representativeness of settings that continue the intervention, as well as the reasons for its continuation, discontinuation, or adaptation. **Individual** At the individual level, it refers to the long-term effects of a programme on outcomes at least six months after the most recent intervention contact.	**When** will (was) the programme become operational? **How long** will (was) it be sustained (setting level)?

Source: Gomes[90] and Glasgow[86]

Nevertheless, since a formal effect evaluation, aimed at determining causal impacts on outcomes, is not feasible within the scope of this one-time process evaluation (see section 4.2 for further details) the effectiveness-dimension will be operationalised as perceived effectiveness. This will reflect the experiences and subjective assessments of service users, parents or legal guardians, and involved

organisations or healthcare providers. This adaptation is made specifically for the present evaluation and should not be interpreted as a general replacement of the effectiveness dimension in future applications of the framework. Should longitudinal or repeated evaluations be undertaken in the future, the effectiveness dimension could be operationalised using objective outcome measures to assess intervention effects. This adaptation reflects the importance of stakeholder perspectives, particularly in complex care pathways where outcomes are influenced by multiple factors and cannot be easily attributed to a single intervention.

For each dimension of the RE-AIM framework, specific outcomes and indicators have been defined to assess key aspects of intervention delivery (see Table 17, Table 18, Table 19, Table 20). These include quantitative indicators as well as qualitative outcomes. For each outcome and indicator, a level is assigned according to the primary unit of analysis. Indicators are classified as individual-level when they reflect characteristics, experiences, behaviours, or outcomes of service users, parents, or healthcare providers. Indicators are classified as organisational-level when they describe the organisation, delivery, uptake, or implementation of an intervention by healthcare providers, treatment programmes, healthcare organisations, or networks. Indicators are classified as population-level when they represent aggregated measures of programme reach, utilisation, or outcomes across the target population. The assigned level therefore reflects the entity to which the indicator most directly relates, rather than the data source from which the information is obtained.

4.3.1 Intervention A: training programme

Intervention A is expected to strengthen healthcare providers' knowledge, confidence, and competencies in the recognition and management of EDs. Improved knowledge and skills are anticipated to facilitate earlier identification, appropriate referral, and timely intervention for individuals with EDs. In turn, earlier access to outpatient care may reduce the need for intensive residential treatment, decrease the likelihood of (re)admissions, and contribute to more efficient use of healthcare resources and overall cost savings.

As described in section 3.2.2, healthcare providers who participate in the training programmes cannot be contacted directly. Consent to share their personal contact details with third parties is not obtained, and their RIZIV-INAMI registration numbers are not collected. Consequently, individual training participants cannot be identified or approached for this evaluation.

This limitation has been taken into account during the development of the evaluation design and data collection strategy. As a result, the evaluation focuses on the perspectives of the GGKJ-SMEA networks responsible for organising and implementing the training programmes, rather than on the experiences of individual participants.

Table 17 – Key implementation outcomes and indicators for intervention A

	Key outcomes and indicators	Level	Data sources
Reach	*Reach of training programmes among healthcare providers*		
	• Number of healthcare providers participating in training programmes	Individual	Annual activity reports
	• Distribution of healthcare providers' characteristics (profession, convention status, network)	Individual	
	Factors affecting reach and representation		
	• Reasons for underrepresentation of certain target groups	Organisational	Focus groups with GGKJ-SMEA networks
Perceived effectiveness	*Perceived satisfaction of participants and impact*		
	• Satisfaction of participants, as perceived by the GGKJ-SMEA networks	Organisational	Focus groups with GGKJ-SMEA networks
	• Perceived impact of the training programmes (e.g. on healthcare providers' skills and practices in the field, etc.)	Organisational	
Adoption	*Adoption of training programmes within GGKJ-SMEA networks*		
	• Number of training programmes organised per year	Organisational	Annual activity reports
	• Distribution of training sessions across GGKJ-SMEA networks	Organisational	
Implementation	*Implementation characteristics of training programmes*		
	• Duration of training programme, number of sessions and timing	Organisational	Annual activity reports
	• Participation channels used	Organisational	
	• Training components used	Organisational	
	• Topics of training programmes	Organisational	
	• Organisations providing training programmes	Organisational	
	• Training formats used (live, blended, online)	Organisational	
Maintenance	*Needs for sustained implementation*		
	• Needs for sustained implementation	Organisational	Focus groups with GGKJ-SMEA networks

4.3.2 *Intervention B: ED care pathway*

Intervention B is expected to improve the timely identification, referral, and treatment of individuals with EDs through coordinated, accessible, and multidisciplinary outpatient care. By facilitating early intervention and ensuring continuity of care across treatment settings, the care pathway is anticipated to support patients in outpatient treatment for as long as clinically appropriate, thereby reducing the need for inpatient and residential admissions and preventing readmissions following discharge. Improved coordination between healthcare providers and services is expected to enhance access to care, shorten waiting times for treatment, increase patient satisfaction through care provided close to home, and promote recovery at an earlier stage of illness. Ultimately, these improvements are anticipated to reduce the number of residential admissions and readmissions, alleviate pressure on waiting lists for intensive treatment, and contribute to a more efficient use of healthcare resources and lower healthcare costs.

Table 18 – Key implementation outcomes and indicators for intervention B

	Key outcomes and indicators	Level	Data sources
Reach	*Service users reached by the care pathway*		
	• Number of service users for whom an ED care pathway has been initiated, stratified by age group, province (proxy for GGKJ-SMEA network)	Population	Administrative data
	• Healthcare provider-perceived underserved patient groups	Individual	Questionnaire healthcare providers
	Awareness		
	• Awareness among healthcare providers	Individual	Questionnaire healthcare providers
Perceived effectiveness	*Perceived experience of care pathway*		
	• Satisfaction: overall satisfaction/dissatisfaction and Net Promoter Score (NPS) style item ○ Of service users ○ Of parents ○ Of healthcare providers	Individual	Questionnaires of service users, parents/legal guardians, and healthcare providers Interviews with service users and parents/legal guardians
	• Parent-reported level of involvement of care	Individual	
	• Perceived improvement (or deterioration) versus pre-pathway care	Individual	
	• (Unexpected/unintended) adverse events of implementing the care pathway	Individual	
	Burden		
	• Parental workload (impact on working hours)	Individual	Questionnaires of parents/legal guardians,
	• Impact on school/work life, social functioning and leisure activities of service users	Individual	Questionnaires of service users and parents/legal guardians
Add	*Characteristics of the care pathways*		

	• Number of care pathways per healthcare provider	Organisational	Administrative data

	• Number of healthcare providers involved in a care pathway
	  ○ Number of different types of healthcare providers
	  ○ Number of healthcare providers by type per care pathway
		Organisational	

	• Number of treatment sessions per care pathway ○ Per type of healthcare provider	Organisational	
Implementation	*Multidisciplinary collaborations and composition*		
	• Number of multidisciplinary meetings per care pathway (capped at two per year)	Organisational	Administrative data
	• Number of care pathways without multidisciplinary consultation	Organisational	Administrative data
	• Proportion of multidisciplinary consultations including (i) a psychologist or educational therapist and (ii) a dietitian (calculated using the total number of initiated care pathways as the denominator)	Organisational	Administrative data
	• Proportion and distribution of multidisciplinary consultations including other healthcare providers	Organisational	Administrative data
	Continuity and renewal of care pathways		
	• Proportion of care pathways renewed after the initial 12-month period, stratified per age group, per province (proxy for GGKJ-SMEA network), and total (calculated using the total number of initiated care pathways as the denominator)	Population	Administrative data
	• Proportion of pathways extended beyond second 12-month period, stratified per age group, per network treatment, and total (calculated using the total number of initiated care pathways as the denominator)	Population	
	• Number of hospital admissions and re-admissions	Population	
	Specialised dietary care		
	• Number of dietitians billing specialised dietary sessions	Organisational	Administrative data
	• Number of individual 60-minute dietary sessions, per patient	Individual	
	• Number of individual 30-minute dietary sessions, per patient	Individual	
Maintenance	*Continuation of care pathways throughout consecutive years*		
	• Year-on-year number of care pathways initiated	Population	Administrative data

	Perceived future of ED care pathway		
	• Patient-, parent- and healthcare provider narratives on the vision of the future of the ED care pathway	Individual	Questionnaires of service users, parents/legal guardians, and healthcare providers Interviews service users and parents/legal guardians
	• Future priorities	Individual	
	• Support needs for sustainability for healthcare providers	Individual	Questionnaire of healthcare providers

4.3.3 *Intervention C and E: multidisciplinary outpatient support teams GGKJ-SMEA and supra-regional*

Intervention C and E are expected to strengthen the capacity of healthcare providers across the ED care continuum to deliver timely, coordinated, and appropriate care. Through specialist consultation, multidisciplinary assessment, case support, knowledge-sharing, and care coordination, the teams are anticipated to improve the early detection, assessment, and management of EDs, while supporting healthcare providers in making timely referral, step-up, and step-down decisions. By facilitating continuity of care and collaboration between ambulatory providers, local hospitals, residential treatment services, specialised centres, and tertiary hospitals, the teams are expected to help maintain patients at the lowest clinically appropriate level of care for as long as possible.

As a result, the support teams are anticipated to reduce unnecessary or prolonged hospitalisations, prevent escalation to more intensive levels of care, facilitate successful transitions from specialised or tertiary treatment back to community-based care, and reduce readmissions. Enhanced collaboration, information exchange, and provider competencies are also expected to improve patient flow across the care continuum, support more timely assessments and treatment decisions, and reduce waiting times for specialised residential and hospital care. Ultimately, these improvements are anticipated to decrease reliance on full-time residential and tertiary inpatient treatment, contribute to more efficient use of healthcare resources, and reduce healthcare costs.

Although the objectives and specifications of the two multidisciplinary outpatient support teams implemented in the transversal ED care model are not exactly the same, they share several similarities. We therefore combined them when defining the process measures and indicators for both interventions. In the final evaluation report, the results for each type of multidisciplinary outpatient support team will be presented separately.

Table 19 – Key implementation outcomes and indicators for intervention C and E

	Key outcomes and indicators	Level	Data sources
Reach	*Volume and characteristics of outpatient requests for support team services per GGKJ-SMEA network per year*		
	• Number of requests received per year	Organisational	Annual activity reports
	• Percentage of requests for which advice is provided	Organisational	
	• Age and gender of the patient to whom the request relates	Individual	
	• Diagnostic category (type of ED) of the patient to whom the request relates	Individual	
	• Case typology of the request (e.g. case support, support with complex care pathways, assessment of range of care services available, involvement in training and exchange of expertise with outpatient care providers)	Organisational	
	• Number of advice or support interventions provided	Organisational	
	• Year-on-year activity levels (stability or growth in number of care requests, number of advice or support interventions provided, number of contacts per request)	Organisational	
	• Number of advices provided per year	Organisational	
	• Type of action/support that followed from the request	Organisational	
	Reach and uptake across networks and provider types		
	• Distribution of requests per outpatient provider type	Organisational	Annual activity reports
	• Distribution of requests per GGKJ-SMEA network/ED reference centre	Organisational	
Perceived effectiveness	*Perceived achievement of objectives*		
	• Extent to which MAST teams perceive their intended objectives	Organisational	Focus groups with GGKJ-SMEA networks/ED reference centres
	• Extent to which actual functioning corresponds to their intended role	Organisational	
	Perceived added value and impact		
	• Perceived extent (or absence) of added value of intervention within the transversal care model	Organisational	Focus groups with GGKJ-SMEA networks/ED reference centres
	• Perceived areas in which MAST-teams have the strongest effect or limited/no effects	Organisational	
	Perceived usefulness of expertise provided in maintaining outpatient care		
	• Reported ability to keep service users in outpatient settings	Organisational	Focus groups with GGKJ-SMEA

	• Perceived proportion of cases where support helped to avoid escalation	Organisational	networks/ED reference centres
Adoption	*Degree of compliance of support teams with the provisions of the RIZIV-INAMI agreement*		
	• Proportion of support teams meeting the mandatory requirements regarding staff	Organisational	Annual activity reports
	• Proportion of supra-regional support teams meeting the mandatory requirements regarding timeliness of support (i.e. provide consult to patient/family within one week after request for temporary intensification)	Organisational	
	Integration of support team function into routine workflow of outpatient providers		
	• Percentage of outpatient providers submitting more than one request annually, average number of cases per care provider/organisation over time	Organisational	Annual activity reports
Implementation	*Timeliness and responsiveness of support provided*		
	• Mean and median days between request and response	Organisational	Annual activity reports
	Continuation of support team activities across consecutive years		
Maintenance	*Continuation of support team activities across consecutive years*		
	• Year-on-year activity levels (stability or growth in activity volume)	Organisational	Annual activity reports
	Stability of multidisciplinary team composition and expertise		
	• Retention and turnover of staff (per discipline)	Organisational	Annual activity reports Focus groups with GGKJ-SMEA networks, ED reference centres
	• Perceived future continuity	Organisational	

4.3.4 *Intervention D and F: part-time treatment programmes GGKJ-SMEA networks and ED reference centres*

Intervention D and F are expected to provide an intermediate level of care that bridges the gap between outpatient treatment and full-time residential care for individuals with EDs. By offering flexible and adaptable treatment intensity tailored to patients' clinical needs and illness severity, these programmes are anticipated to support both the prevention of residential admissions and the successful transition from residential treatment to lower levels of care.

Through the provision of structured part-time treatment, the programmes are expected to facilitate seamless movement between levels of care, enabling patients to receive the appropriate intensity of treatment at the appropriate time. This is anticipated to improve continuity of care, reduce disruptions during care transitions, and lower the risk of readmission following discharge from residential treatment. In addition, timely access to part-time treatment is expected to enhance access to appropriate care and reduce reliance on full-time residential treatment, including tertiary residential treatment when clinically appropriate.

By matching treatment intensity more closely to individual needs throughout the course of illness, the programmes are anticipated to improve patient outcomes and support recovery while allowing patients to remain connected to their home, family, educational, and social environments. The flexible and

personalised nature of the programmes is also expected to increase patient and family satisfaction. Ultimately, by preventing avoidable residential admissions, reducing repeated admissions, and shortening the duration of intensive treatment episodes, the part-time treatment programmes are anticipated to contribute to a more efficient use of healthcare resources and lower healthcare costs.

For the two part-time treatment programmes included in the transversal ED care model, the measures and indicators to be assessed have been combined because these interventions are highly similar. In the final evaluation report, the results will be presented separately for each type of part-time treatment programme.

Table 20 – Key implementation outcomes and indicators for intervention D and F

	Key outcomes and indicators	Level	Data sources
Reach	*Service users reached by part-time treatment programmes*		
	• Number of referrals received per year	Organisational	Administrative data Annual activity reports
	• Number of service users enrolled in a part-time treatment programmes	Organisational	
	• Inpatient and outpatient attendance at part-time treatment programmes	Organisational	
	• Drop-out of service users in the part-time treatment programmes	Organisational	
	• Stratified per age group, network of treatment	Organisational	
Perceived effectiveness	*Experience of part-time treatment programme and (i)MFT sessions*		

	• Satisfaction: overall satisfaction/dissatisfaction and NPS style item
	  ○ Of service users
	  ○ Of parents
		Individual	Questionnaires of service users and parents/legal guardians
			Interviews service users and parents/legal guardians

	• Usefulness and appropriateness of programme intensity	Individual	
	• Usefulness and appropriateness of (i)MFT sessions	Individual	
	• (Unexpected/unintended) adverse events of implementing the part-time treatment programmes	Individual	
Adoption	*Organisation of part-time treatment programmes*		
	• Type and number (FTE) of healthcare providers involved in the part-time treatment programmes	Organisational	Annual activity reports
	• Compliance with required staffing standards for the part-time treatment programmes	Organisational	
	• Number of GGKJ-SMEA networks/reference centres that offer part-time treatment programmes	Organisational	
Implement ation	*Compliance with minimum programme intensity requirements*		
	• Number of iMFT sessions per year	Organisational	Administrative data Annual activity reports
	• Number of families per iMFT session	Organisational	

	• Inpatient and outpatient attendance at iMFT sessions	Organisational	
	Average dose of treatment received per patient		
	• Total number of half-days attended	Individual	Administrative data Annual activity reports
	• Mean number of half-days attended per week	Individual	
Maintenance	*Continuation of part-time treatment programmes throughout consecutive years*		
	• Year-on-year number of part-time programmes initiated	Organisational	Administrative data Annual activity reports
	• Year-on-year number of (i)MFT sessions	Organisational	

4.4 Mechanisms of change

This domain of the process evaluation aims to explore how and why the interventions within the transversal care model are expected to produce their intended effects. In line with the MRC framework, the focus is not on measuring outcomes per se, but on examining the underlying processes, interactions, and stakeholder responses through which change is generated.[85]

Within this evaluation, mechanisms of change are conceptualised as the causal pathways linking intervention components to intermediate processes (e.g. collaboration, engagement) and, ultimately, to perceived improvements in care experiences and functioning. These mechanisms are not assumed to operate uniformly across settings, they are understood to be context-dependent and shaped by barriers and facilitators identified in the contextual analysis.

The transversal care model is based on the overarching assumption that enhanced coordination, continuity of care, and collaboration across providers and care levels will lead to improved care experiences and perceived outcomes for children and young people with EDs. Building on this, the process evaluation will examine a set of specific, theory-informed mechanisms of change, operationalised through the hypotheses outlined below.

Key hypothesised mechanisms include:

- **Improved multidisciplinary collaboration**, contributing to better alignment of care and coordination across providers;
- **Enhanced provider knowledge and expertise**, supporting earlier detection and more appropriate referral pathways;
- **Improved accessibility and reduced barriers to care**, leading to higher engagement and adherence to treatment;
- **Patient- and family-centred care processes**, including strong therapeutic relationships and shared decision-making;
- **Active involvement of families**, particularly through structured interventions such as (i)MFT, supporting engagement and recovery;
- **Availability of provider support structures**, such as multidisciplinary outpatient support teams, enhancing decision-making and care quality.

These mechanisms are interconnected and may reinforce each other. For example, improved provider knowledge may facilitate more appropriate referrals, which in turn enhances coordination and accessibility. At the same time, their effectiveness is expected to depend on contextual conditions, including organisational capacity, policy frameworks, and characteristics of the target population. Barriers (e.g. limited time, administrative burden, low uptake of specific interventions) and facilitators (e.g. strong network structures, structured care pathways) identified in the context domain will therefore be explicitly considered when interpreting whether and how mechanisms are activated.

Data collection will focus on capturing stakeholder perspectives, including those of service users, parents or legal guardians, and healthcare providers, using qualitative methods such as interviews and focus groups, complemented by relevant quantitative indicators where available. For several topics, the results of the annual activity reports and preliminary results of the questionnaires will be used to inform focus group discussions, during which several issues can be further explored.

Table 21 – Mechanisms of change

Hypotheses	Key outcomes and indicators	Level	Data sources
Improved multidisciplinary collaboration leads to better coordinated and continuous care *Intervention B, C, E*	*Multidisciplinary collaboration*		
	• Number of multidisciplinary consultations	Individual Organisational	Administrative data
	Perceived coordination		
	• Patient-reported communication/exchange of information between healthcare providers	Individual	Questionnaires with service users and parents/legal guardians Interviews with service users and parents/legal guardians
	• Smooth transitions across care levels	Individual	
	• Patient-reported fragmentation of care	Individual	
Increased provider knowledge and expertise improves early detection and referral *Intervention A, downstream effects on intervention B and C*	*Provider competence*		
	• Self-reported competence of EDs	Individual	Healthcare provider questionnaire
	Early detection		
	• Time from symptom onset to ED care pathway activation or first consultation	Individual	Questionnaires with service users and parents/legal guardians Interviews with service users and parents/legal guardians
Accessibility and reduced barriers increase engagement and adherence to care *Intervention A, B, D, F*	*Accessibility of care*		
	• Waiting times, ease of entry	Individual Organisational	Questionnaires with service users and parents/legal guardians Interviews with service users and parents/legal guardians Annual activity reports
	Engagement		
	• Attendance rates, early drop-outs	Organisational	Annual activity reports
	Adherence		

Hypotheses	Key outcomes and indicators	Level	Data sources
	• Completion of ED care pathway or part-time treatment programme	Individual Organisational	Questionnaires with service users and parents/legal guardians Interviews with service users and parents/legal guardians Annual activity reports
	Perceived facilitators and barriers by patients, parents and healthcare providers		

	• Practical, structural, emotional and organisational facilitators and barriers
	  ○ For reaching specific professional groups with training programmes
	  ○ For participation in and adhesion to care pathway/part-time treatment programmes and/or (i)MFT sessions
		Individual
		Organisational
			Questionnaires of service users, parents/legal guardians, and healthcare providers
			Interviews with service users and parents/legal guardians
			Focus groups with GGKJ-SMEA networks and ED reference centres

Patient-centred care and therapeutic relationships improve perceived quality and outcomes *Intervention B, D, F*	*Therapeutic alliance*		
	• Trust, feeling understood	Individual	Questionnaires with service users and parents/legal guardians Interviews with service users and parents/legal guardians
	Patient and parental involvement		
	• Perceived shared-decision making	Individual	Questionnaires with service users and parents/legal guardians Interviews with service users and parents/legal guardians
	Perceived quality of care		
	• Satisfaction	Individual	Questionnaires with service users and parents/legal guardians Interviews with service users and parents/legal guardians
	• Perceived usefulness	Individual	
	• Perceived improvement in wellbeing	Individual	

Hypotheses	Key outcomes and indicators	Level	Data sources
Family involvement enhances treatment engagement and recovery processes *Intervention D and F*	*Family involvement*		
	• Perceived parental involvement and support	Individual	Questionnaires with service users and parents/legal guardians Interviews with service users and parents/legal guardians Annual activity reports
	• Participation in MFT/iMFT sessions	Organisational	
	• Patient and parent-reported benefits	Individual	
Support structures for providers (e.g. MAST-EMAS teams) enhance decision-making and care quality *Intervention C and E*	*Use of support teams*		
	• Frequency of consultations	Organisational	Annual activity reports
	• Confidence in handling complex cases	Individual	Healthcare provider questionnaire

Intervention A: training programme, Intervention B: ED care pathway; Intervention C: multidisciplinary outpatient support teams, Intervention D: Ambulatory part-time treatment programme GGKJ-SMEA, Intervention E: supra-regional multidisciplinary outpatient support teams, Intervention F: part-time treatment programme in ED reference centres

4.5 Context

The context-domain of the process evaluation will aim to identify and understand the external and internal factors that may influence the implementation and functioning of the interventions of the transversal care model for children and young people with EDs (see Table 22). Given the complexity of the care model, characterised by multiple providers, care levels and transitions, context is expected to play a role in shaping both implementation processes and the functioning of the interventions over time.

This component of the process evaluation will examine factors at multiple levels, including:

- Macro level: including the broader policy environment, funding structures, and regulatory frameworks governing the transversal care model;
- Meso level: including organisational characteristics, inter-organisational collaboration, and service capacity across GGKJ-SMEA networks and ED reference centres;
- Micro level: including professional practices, team dynamics, and patient population characteristics, etc.

Particular attention will be given to contextual elements that may act as barriers or facilitators to implementation, including variation across regions, differences in organisational capacity, and challenges related to accessibility, coordination and equity given the decentralised and evolving nature of several interventions within the transversal care model, contextual heterogeneity is expected to be an important determinant of how interventions are implemented and experienced in practice. To capture these dimensions, contextual data will be collected using a mixed-methods approach, combining quantitative data sources with qualitative methods. These insights will support the interpretation of findings across the RE-AIM dimensions and inform recommendations for the future optimisation, scale-up, or adaptation of the transversal care model.

Table 22 – Context

Hypotheses	Key outcomes and indicators	Data sources
Regional and organisational context influences implementation variability and accessibility *All six interventions*	*Geographical variation* • Variation in uptake across, healthcare providers, GGKJ-SMEA networks and ED reference centres • Availability of services	Focus groups with GGKJ-SMEA networks and ED reference centres Administrative data Annual activity reports
	Organisational capacity • Staffing levels (FTEs per intervention) • Availability of multidisciplinary expertise	Focus groups with GGKJ-SMEA networks and ED reference centres Annual activity reports
	Accessibility • Waiting times for care (ED care pathway entry, treatment start)	Focus groups with GGKJ-SMEA networks and ED reference centres Annual activity reports
	Variation in implementation • Differences in training programme content • Heterogeneity in part-time treatment programme structure	Focus groups with GGKJ-SMEA networks and ED reference centres Annual activity reports
	Barriers and facilitators to implementation • Barriers (e.g. limited capacity, decentralisation variability) • Facilitators (e.g. strong networks, existing expertise)	Focus groups with GGKJ-SMEA networks and ED reference centres Interviews with service users and parents/legal guardians
Policy, regulatory, and financial context shape implementation and engagement *All six interventions*	*Clarity of policy and reimbursement rules* • Understanding eligibility criteria and procedures (e.g. activation of ED care pathway)	Healthcare provider questionnaire
	Financial adequacy • Perceived sufficiency of funding (e.g. MAST-EMAS budget, part-time treatment programmes, fees)	Focus groups with GGKJ-SMEA networks and ED reference centres
	Administrative burden • Time spent on reporting, billing, coordination tasks	Healthcare provider questionnaire
	Alignment across systems • Coordination between federal and regional levels • Alignment across sectors (health, social, education)	Focus groups with GGKJ-SMEA networks and ED reference centres Interviews with service users and parents/legal guardians
	Barriers and facilitators to implementation • Barriers (e.g. administrative complexity, unclear reimbursement, sufficiency of reimbursement)	Focus groups with GGKJ-SMEA networks and ED reference centres Interviews with service users and parents/legal guardians

Hypotheses	Key outcomes and indicators	Data sources
	• Facilitators (e.g. earmarked funding, formal agreements)	
Characteristics of the target population influence access, engagement, and equity *Intervention B, D, F (primarily)*	*Sociodemographic variation* • Age group differences in care use • Differences in preferential reimbursement	Administrative data Questionnaires with service users and parents/legal guardians
	Clinical complexity • Diagnostic categories • Severity influencing level of care	Focus groups with GGKJ-SMEA networks and ED reference centres Interviews with service users and parents/legal guardians
	Family context • Degree of parental involvement	Interviews with service users and parents/legal guardians
	Barriers and facilitators to implementation • Barriers (e.g. stigma, access issues) • Facilitators (e.g. family involvement, early help-seeking)	Focus groups with GGKJ-SMEA networks and ED reference centres Interviews with service users and parents/legal guardians
Interorganisational collaboration and network functioning shape care continuity *Intervention B, C and E*	*Coordination of care* • Frequency and quality of multidisciplinary consultations	Healthcare provider questionnaire Administrative data Focus groups with GGKJ-SMEA networks and ED reference centres
	Role clarity • Clear responsibility across providers	Healthcare provider questionnaire Focus groups with GGKJ-SMEA networks and ED reference centres
	Continuity of care • Smooth transitions between care levels	Focus groups with GGKJ-SMEA networks and ED reference centres Interviews with service users and parents/legal guardians
	Information exchange • Perceived effectiveness of communication	Healthcare provider questionnaire Focus groups with GGKJ-SMEA networks and ED reference centres Interviews with service users and parents/legal guardians
	Barriers and facilitators to implementation • Barriers (e.g. unclear roles, weak coordination) • Facilitators (e.g. established collaboration structures)	Focus groups with GGKJ-SMEA networks and ED reference centres Interviews with service users and parents/legal guardians

Intervention A: training programme, Intervention B: ED care pathway; Intervention C: multidisciplinary outpatient support teams, Intervention D: Ambulatory part-time treatment programme GGKJ-SMEA, Intervention E: supra-regional multidisciplinary outpatient support teams, Intervention F: part-time treatment programme in ED reference centres

5 DESIGN AND OPERATIONALISATION OF THE EVALUATION FRAMEWORK

KEY POINTS

- The content of this chapter relates exclusively to a process evaluation. As explained in Chapter 4, this one-time evaluation does not include an effect or outcome evaluation, due to methodological limitations associated with the implementation of the different interventions in the transversal care model.
- A mixed-methods design will be used, integrating quantitative and qualitative data sources to obtain a comprehensive understanding of the implementation and functioning of the transversal care model.
- Quantitative data will be collected through annual activity reports, administrative databases, and cross-sectional questionnaires among service users, parents or legal guardians, and healthcare providers.
- Qualitative data will be collected through focus group discussions with provider organisations and individual interviews with service users and parents or legal guardians.
- Special attention is given to identifying implementation barriers and facilitators, contextual influences, collaboration mechanisms, and factors affecting sustainability.
- Quantitative and qualitative findings will be triangulated to strengthen the validity of conclusions and provide actionable recommendations for the future of the transversal care model for children and young people with an ED in Belgium.
- Specific feasibility safeguards are incorporated to ensure that certain evaluation components are only conducted when sufficient implementation and participation levels are achieved.

5.1 Introduction: mixed-methods design

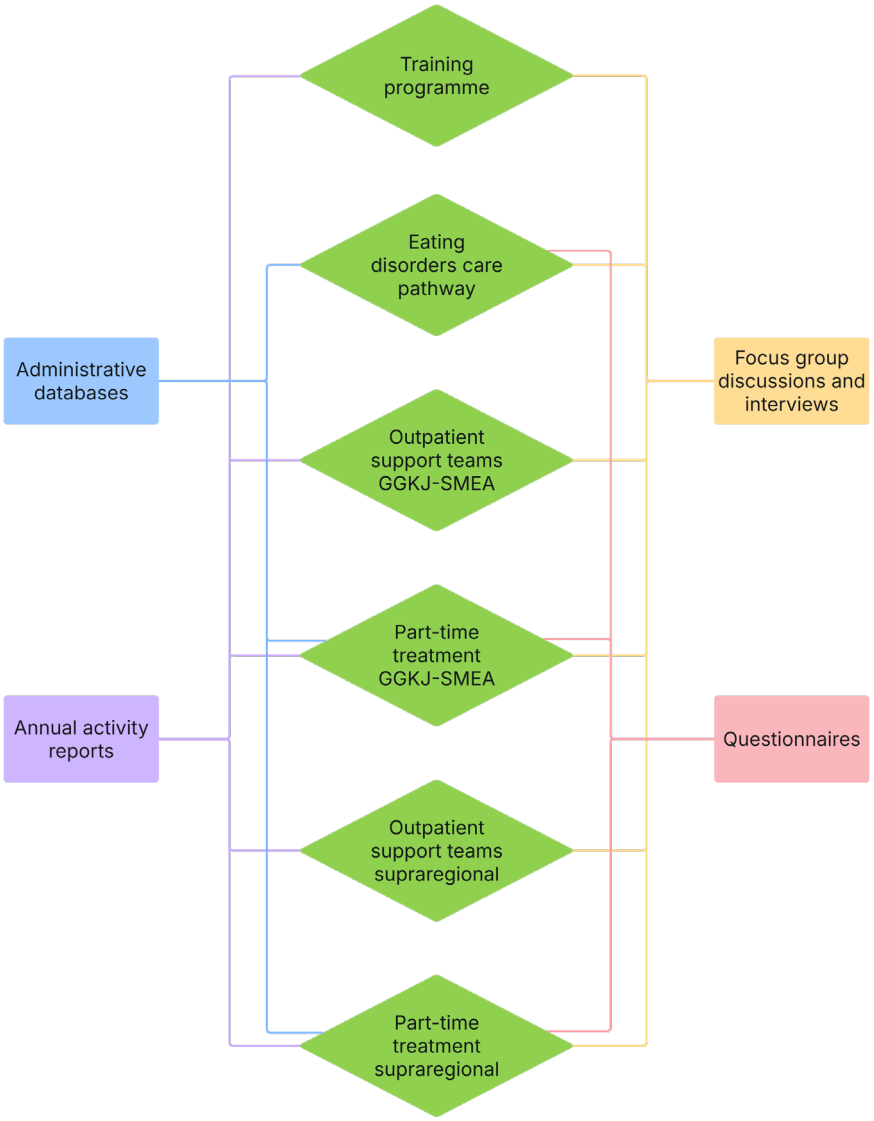
The process evaluation of the transversal care model for children and young people with EDs will be based on a mixed-methods design, integrating multiple data sources and stakeholder perspectives (including GGKJ-SMEA network representatives, ED reference centre representatives, adolescents and young adults with EDs and their parents or legal guardians). As illustrated in Figure 5, the evaluation covers the full range of implemented interventions. These are assessed using complementary data sources, including annual activity reports, administrative databases, as well as qualitative data collection and cross-sectional questionnaires among service users and their parents or legal guardians. Appendix 4 provides a detailed overview of the data sources that will be used in the process evaluation of each intervention.

The integration strategy is based on triangulation of quantitative and qualitative evidence at the data collection, analysis and interpretation stages. First, preliminary quantitative findings from the annual activity reports, administrative databases and questionnaires have informed the development of the focus group and interview guides, allowing qualitative data collection to explore and explain emerging patterns in implementation and service uptake. Second, quantitative indicators on the uptake and implementation of interventions will be used to purposively select networks and reference centres with contrasting levels of implementation performance for qualitative investigation. This will enable in-depth exploration of factors that facilitate or hinder successful implementation. Finally, findings from the quantitative and qualitative strands will be integrated during interpretation and reporting using a triangulation approach. Results will be organised according to the RE-AIM framework, with quantitative indicators and qualitative findings examined side by side for each dimension. Areas of convergence, complementarity and divergence between data sources will be systematically assessed. In cases

where findings diverge, these discrepancies will be treated as informative results and explored further to identify contextual factors, stakeholder perspectives or implementation mechanisms that may explain the observed differences.

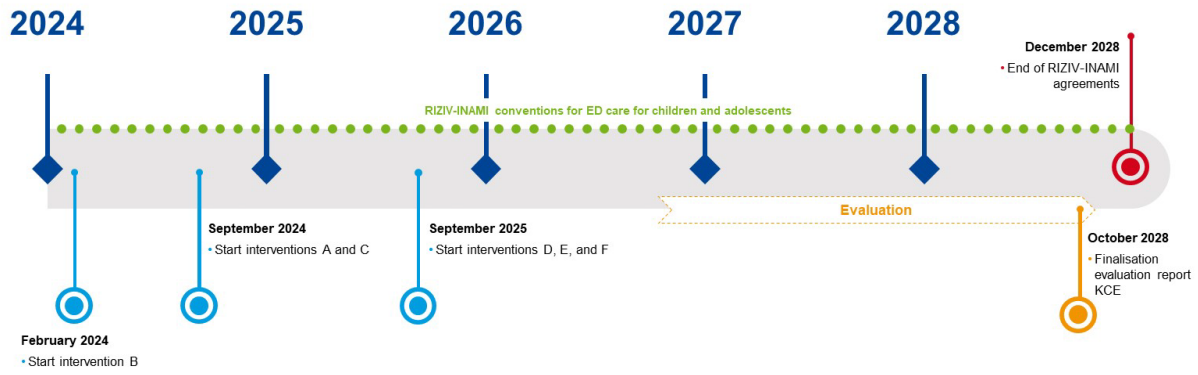
While the transversal care model is intended for the broader population of children and young people with ED aged up to 24 years, the process evaluation will specifically focus on adolescents and young adults aged 10-24 years (see also section 3.1). This decision is based on preliminary implementation data indicating that the large majority of service users enrolled in the interventions fall within this age range. Consequently, children younger than 10 years and adults older than 24 years will not be included in the questionnaire and interview components of the evaluation.

Figure 5 – Overview of interventions and corresponding data sources for evaluation



The timing of the implementation and evaluation activities is presented in Figure 6. Interventions were gradually rolled out between 2024 and 2025, while the evaluation runs from late 2026, following the anticipated approval of the evaluation study protocol by the KCE Board of Directors, expected in October 2026, through to beginning 2028. Data collection will be conducted longitudinally across reporting cycles and aligned with key milestones, culminating in a final evaluation report to be presented to the KCE Board of Directors in October 2028. This timeline is appropriate, as the RIZIV-INAMI agreements for EDs end in December 2028, allowing sufficient time to prepare its continuation, make any necessary adjustments, or plan its conclusion.

Figure 6 – Project timeline process evaluation transversal care model for adolescents and young adults with EDs



Note: each green dot represents a month.

Intervention A: training; intervention B: ED care pathway; intervention C: multidisciplinary outpatient support teams GGKJ-SMEA; intervention D: ambulatory part-time treatment programme GGKJ-SMEA; intervention E: supra-regional multidisciplinary outpatient support teams; intervention F: part-time treatment programme in ED reference centres

5.2 Quantitative data collection methods and analysis

5.2.1 Introduction

To quantify the implementation and uptake of the interventions, assess patterns of service use, and measure key process indicators, a quantitative data collection component will be conducted using multiple structured data sources, including annual activity reports, administrative databases, and cross-sectional questionnaires. The quantitative component aims to generate standardised and comparable data to assess implementation fidelity, coverage, accessibility, and variation across settings, and to complement the qualitative findings by providing measurable evidence on the functioning and performance of the transversal care model.

5.2.2 Annual activity reports

In accordance with the provisions set out in the agreement between RIZIV-INAMI and the GGKJ-SMEA networks and ED reference centres, these entities are required to submit an annual activity report no later than 30 April of the year following the reporting period (year x+1).

Within these annual activity reports, the GGKJ-SMEA networks report on the activities related to different interventions (A, C, and D). ED reference centres report on the activities of interventions E and F.

For the reporting years 2024 and 2025, standardised templates were used to guide data collection (Appendix 2.1 and 2.2). The 2025 template was a slightly revised version of the 2024 template, reflecting initial user feedback. In 2024, activity reports were completed and submitted via a web-

based reporting system. Based on feedback regarding usability and accessibility, the 2025 reports were completed using a Word-based template, which was subsequently submitted via email.

The templates used in 2024 and 2025 relied heavily on open-ended response fields, allowing GGKJ-SMEA networks and ED reference centres to provide qualitative and narrative information. While this approach enabled rich contextual insights, it also introduces important limitations for systematic analysis, including heterogeneity in reporting formats, variable levels of detail, and reduced comparability across organisations and reporting periods. Several submitters explicitly noted that the current annual activity report template lacks clearly defined indicators aligned with their core mandate and activities (Chapter 3).

To address these limitations and enhance the evaluability of the collected data, a revised and more structured reporting template has been developed for the 2026 and 2027 reporting cycles. This revised template, developed in consultation with RIZIV-INAMI and the FPS Public Health, is intended to support more robust data analysis and strengthen comparability across organisations and reporting periods. It includes:

- predefined response categories and closed-ended questions to facilitate quantitative analysis,
- standardised measurements aligned with the objectives of the care model,
- clear definitions and reporting instructions to improve consistency and data quality,
- where relevant, limited structured open-text fields to capture contextual or explanatory information.

Reporting templates will be made available to GGKJ-SMEA networks and ED reference centres in a timely manner before the following reporting cycle, allowing adequate time for preparation and implementation. This will enable organisations to align their registration practices with the reporting requirements and ensure that relevant information is collected prospectively.

In addition, efforts will be made to ensure alignment between the activity report variables and the broader evaluation framework, including linkage with other data sources where feasible (e.g. administrative databases, qualitative data collection). Data obtained through the annual activity reports will contribute to the process evaluation, enabling the assessment of implementation fidelity, coverage, and variation across settings.

Finally, data quality checks (e.g. completeness, internal consistency) will be conducted upon receipt of the reports. Where necessary, follow-up clarification may be requested from reporting entities to ensure accuracy and interpretability of the data.

The revised structured templates for the annual activity reports for the 2026 and 2027 reporting cycles are available upon request.[v]

5.2.2.1 Timeline

The GGKJ-SMEA networks and ED reference centres are required to prepare and submit an annual activity report to RIZIV-INAMI by 30 April of each year following the reporting year (year x+1), with an exception until 31 May for the current reporting cycle (i.e. 2026).

In a further refinement of the timeline, and in consultation with RIZIV-INAMI and the FPS Public Health, it is agreed to advance the submission deadline for the 2027 reporting year (to be submitted in 2028). Specifically, GGKJ-SMEA networks and ED reference centres will be required to submit their annual activity reports by 29 February 2028.

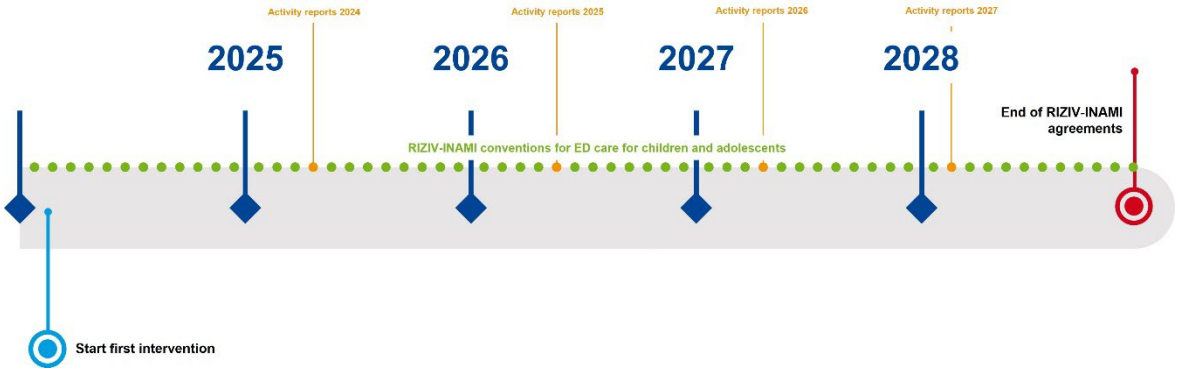
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[v] Annual activity reports must be approved by the steering committee (begeleidingscomité-comité d'accompagnement) of the respective RIZIV-INAMI agreements. At the time of publication of this protocol, such approval is pending.

This adjustment is intended to ensure that the reported data are available in a timely manner for inclusion in the final evaluation report, which is scheduled to be presented to the KCE Board of Directors in October 2028.

An overview of the reporting deadlines of these annual activity reports is provided in Figure 7.

Figure 7 – Timeline reporting periods and deadlines annual activity reports



Note: each green dot represents a month.

5.2.3 Administrative databases

5.2.3.1 Objective

This section describes the use of administrative databases for three distinct purposes. First, these databases will support the evaluation of outcomes within the RE-AIM framework. Second, they will be used to analyse selected service user-relevant outcome indicators among individuals for whom an ED care pathway has been initiated, particularly hospital admissions and patient journeys. Thirdly, they will be used for epidemiological analyses of hospital admissions among service users with EDs.

For the RE-AIM outcomes evaluation, administrative databases will only be used for interventions B (ED care pathway), D (ambulatory part-time treatment programme GGKJ-SMEA), and F (part-time treatment programme in ED reference centres). Administrative databases do not provide relevant information for interventions A (training programme), C (multidisciplinary outpatient support teams), or E (supra-regional multidisciplinary outpatient support teams); therefore, these interventions are excluded from the administrative data analyses.

5.2.3.2 Selection of administrative national databases

IMA-AIM and EPS

The Intermutualistic Agency (IMA-AIM) database (Box 8) will be used to assess outcomes defined within the RE-AIM framework, and for selected service user-relevant outcome indicators among individuals for whom an ED care pathway has been initiated.

Box 8 – Intermutualistic Agency (IMA-AIM) database

IMA-AIM is a non-profit organisation that collects, manages, and analyses data on healthcare reimbursements covered by the Belgian compulsory health insurance system. These data are provided by the seven Belgian health insurers and include information on all reimbursed healthcare services, such as consultations, pharmaceuticals, diagnostic procedures, and therapeutic interventions. The database also contains selected socio-demographic and social security-related information relevant to reimbursement decisions.

The IMA-AIM database consists of three main datasets: (i) the Population dataset, containing beneficiary characteristics; (ii) the Health Care dataset, containing reimbursed healthcare services; and (iii) the Pharmanet dataset, containing reimbursed medication claims.[91]

Given the relatively low prevalence of EDs (section 2.3), the analyses for this process evaluation will require access to the full IMA-AIM database. The Permanent Sample (EPS), a subset of the IMA-AIM database, is unlikely to provide a sufficient sample size for the planned analyses. Nevertheless, the analyses will initially be developed and tested using the EPS database, which can be accessed more rapidly by KCE.

The pseudo-nomenclature codes specified in the RIZIV-INAMI agreements are registered in the IMA-AIM database, allowing the identification of service users who initiate an ED care pathway (intervention B). However, these codes relate exclusively to outpatient care and do not capture hospital admissions for EDs. While hospital admissions among service users enrolled in intervention B (ED care pathway) can be identified within IMA-AIM, the underlying reason for admission cannot be determined. This is because hospital admissions are not covered by the RIZIV-INAMI agreements, and the database does not contain diagnostic information for hospital stays (Table 23). Furthermore, neither the IMA-AIM database nor the EPS database contains suitable proxy measures to identify an ED diagnosis. Disease-specific information related to hospital admissions is available only through the TCT and MPG-RPM databases.

TCT and MPG-RPM

The Technical Cell (TCT) and Minimal Psychiatric Data (MPG-RPM) databases (Box 9) will be used to analyse epidemiological outcomes related to hospital admissions among service users with EDs.

Box 9 – TCT and MPG-RPM databases

The TCT database is managed jointly by RIZIV-INAMI and the FPS Public Health, Safety of the Food Chain and Environment. Its primary mission is to collect, link, validate, and pseudonymise hospital-related data. Each year, the TCT links data from the Minimal Hospital Data (MZG-RHM) with hospital billing data from the Anonymous Hospital Stays dataset (AZV-SHA) and Anonymous Day Hospitalisation (ADH-HJA) datasets. This linkage enables analyses of the relationship between healthcare expenditures and treated conditions.[91]

The MPG-RPM database contains mandatory clinical registration data for: (i) admissions to psychiatric hospitals; (ii) complete psychiatric stays in psychiatric departments of general hospitals (PAAZ-SPHG); and (iii) partial psychiatric stays in PAAZ-SPHG departments, although only for the period spent in the psychiatric department and not for the entire hospital stay.

The TCT database contains information on admissions to general hospitals only and does not include admissions to psychiatric hospitals, as MPG-RPM data are not integrated into the TCT database. However, the database does include admissions to PAAZ-SPHG departments, including both complete and partial psychiatric stays. A complete psychiatric stay refers to a hospitalisation that takes place entirely within a PAAZ-SPHG department. A partial psychiatric stay refers to a hospitalisation during which the patient spends part of the stay in a PAAZ-SPHG department and part in one or more non-psychiatric departments of the same general hospital.

An important limitation of the TCT database concerns diagnostic registration. For admissions to non-psychiatric departments, registration of all diagnoses, including psychiatric diagnoses, is mandatory. In contrast, for complete or partial stays involving PAAZ-SPHG departments, the registration of both somatic and psychiatric diagnoses is not mandatory. As a result, diagnostic information for psychiatric admissions in the TCT database may be incomplete.

From a technical and legal perspective, IMA-AIM data can be linked to TCT data but not to MPG-RPM data. Although TCT includes diagnostic information, it will not be used to assess outcomes within the RE-AIM framework. This decision is based on two considerations:

- Only a limited proportion of service users for whom an ED care pathway is initiated are expected to be hospitalised. One of the main objectives of the ED care pathway is to support service users in the outpatient setting and prevent hospital admission whenever possible.
- TCT data become available with a considerable delay. Given the recent implementation of the ED care pathway (February 2024) and the timelines of the current process evaluation study, analyses based on TCT data are unlikely to provide meaningful or sufficiently mature information for the evaluation of RE-AIM outcomes.

Doc. N

In addition to the IMA-AIM database, the Doc. N database (Box 10) will be used to assess outcomes within the RE-AIM framework. Because Doc. N data become available earlier than the corresponding IMA-AIM data, they enable more timely monitoring of the implementation and uptake of the ED care pathway.

Box 10 – Doc. N database

Doc. N is a national RIZIV-INAMI reimbursement database that provides aggregated monthly statistics on healthcare activities and expenditures. The database contains information on the number of reimbursed services and associated reimbursement amounts, stratified by (pseudo-) nomenclature code, age group, sex, geographical area, and other demographic characteristics. Data are updated monthly and become available approximately 3 to 4 months after service delivery.

Aggregated data for the relevant pseudo-nomenclature codes will be requested directly from RIZIV-INAMI for use in the analyses.

Overview psychiatric hospitalisations in administrative databases

Table 23 provides an overview of the three types of psychiatric hospital admissions: (i) admissions to a psychiatric hospital; (ii) complete psychiatric stays in a PAAZ-SPHG departments; and (iii) partial psychiatric stays in a PAAZ-SPHG departments.

For each admission type, the table indicates the administrative databases in which the information is available and specifies the type of information recorded, including non-psychiatric diagnoses, psychiatric diagnoses, therapeutic information, and billing information. Although billing information is available in several databases, it will not be used in this process evaluation and is included in the table for completeness only.

For reporting purposes, complete psychiatric stays in a PAAZ-SPHG and the PAAZ-SPHG component of partial psychiatric stays are combined in the second section of the table (“Partial or complete PAAZ-SPHG”). The third line includes the non-PAAZ-SPHG component of partial psychiatric stays, as well as hospital stays that take place entirely outside a PAAZ-SPHG. This distinction is relevant because these data also capture service users with psychiatric diagnoses registered outside the PAAZ-SPHG setting.

Table 23 – Database information on psychiatric admissions in different hospital settings

Type of admission	Database	Included	Somatic diagnoses	Psychiatric diagnoses	Therapeutic information	Billing information
Psychiatric hospital	IMA-AIM	Yes	No	No	Reimbursed services only	Yes
	TCT	No				
	MPG/RPM	Yes	ICD-9-CM	DSM-IV	Optional	No
	Doc. N	Yes	No	No	Reimbursed services only	Yes
Partial or complete PAAZ-SPHG stay	IMA-AIM	Yes	No	No	Reimbursed services only	Yes
	TCT	Yes	Not obligatory (ICD-10-BE)	Not obligatory	Reimbursed services only (classical hospitalisations**)	Yes
	MPG/RPM	Yes	ICD-9-CM	DSM-IV	Optional	No
	Doc. N	Yes	No	No	Reimbursed services only	Yes
Non-PAAZ-SPGH stay part or non-PAAZ-SPHG hospital stay*	IMA-AIM	Yes	No	No	Reimbursed services only	Yes
	TCT	Yes	Obligatory (ICD-10-BE)	Obligatory (ICD-10-BE)	Procedures (ICD-10-BE) + reimbursed services (classical hospitalisations + day hospitalisations	Yes
	MPG/RPM	No				
	Doc. N	Yes	No	No	Reimbursed services only	Yes

** Data registration of "non-PAAZ-SPHG" part of service users with partial psychiatric stays in PAAZ/SPHG and of service users without stay on psychiatric ward*
*** Classical hospitalisation: at least one night*
IMA-AIM: InterMutualistisch Agentschap-Agence InterMutualiste; Mixed: mixed somatic-psychiatric admissions; MPG-RPM: Minimale Psychiatrische Gegevens-Résumé Psychiatrique Minimum; PAAZ-SPHG: Psychiatrische Afdeling in een Algemeen Ziekenhuis-Service Psychiatrique d'un Hôpital Général; TCT= Technische Cel-Cellule Technique

5.2.3.3 Data selection

DATABASE DELAY AND TIMELINES

In the context of administrative databases, delay refers to the time interval between the occurrence of an event, such as healthcare utilisation or a hospital admission, and the moment the corresponding data become available for analysis by KCE. Table 24 provides an overview of the expected data availability delays for each of the administrative databases described above.[91]

Table 24 – Delay in database availability

Database	Delay
IMA-AIM	At least 1 year (data complete ±86% after 1 year, ± 99% after 18 months)
TCT	Approximately 2.5 years
MPG-RPM	January-June data: available in MPG-RPM by the end of September July-December data: available in MPG-RPM by the end of March in the following year
Doc. N	3 to 4 months after the intervention

Intervention B (ED care pathway) became operational on 1 February 2024. Taking the data availability delays described above into account, an extraction from the IMA-AIM database no earlier than December 2027 would allow the inclusion of data covering the period from February 2024 through at least December 2026 for the outcomes defined within the RE-AIM framework. However, while data for 2024 and 2025 will be complete, data for 2026 will only be partially available (Table 24). For some RE-AIM outcomes, more recent information may be obtained from the Doc. N database.

For analyses based on the TCT database, data will be included from January 2023 onwards. Consequently, a data extraction no earlier than December 2027 would provide complete information for the period 2023-2025. Although more recent data may be available in the MPG-RPM database, only data covering the same period will be extracted to ensure consistency across data sources.

SELECTION OF SERVICE USERS

The target population of the transversal care model for EDs is described in section 3.1, i.e. children and young people up to 24 years of age with an ED diagnosis who are not admitted to hospital for ED treatment.

- **RE-AIM outcomes**

Within national administrative databases, service users with an ED cannot be reliably identified in ambulatory care settings unless they have been enrolled in intervention B (ED care pathway) by a physician. Furthermore, no suitable proxy indicators for EDs are available in administrative data, such as disease-specific medication use. As a result, administrative databases alone do not allow the identification of the entire population of individuals aged 0 to 24 years with an ED.

Therefore, for the analyses of RE-AIM framework outcomes based on the IMA-AIM database, the study population will be restricted to service users who have been enrolled in intervention B. These individuals can be identified through the specific pseudo-nomenclature code assigned to the care pathway. More specifically, the study population will include all service users for whom pseudo-nomenclature code **401295** has been reimbursed (Appendix 5).

In addition, the study population will include service users aged 0 to 24 years for whom one of the pseudo-nomenclature codes related to psychological treatment or support for EDs (Appendix 6) has been registered within the framework of the agreement between RIZIV-INAMI and the GGKJ-SMEA networks on the financing of the primary psychological function (Box 5).

Eligibility is determined at the time of enrolment in intervention B. Consequently, service users who turn 24 years of age during the follow-up period will remain eligible and will continue to be included in the analyses.

- **Service user-relevant outcome indicators**

In the absence of an appropriate comparator group, service user-relevant outcome indicators cannot be directly attributed to the transversal care model. Therefore, these indicators are not included within the RE-AIM framework.

Hospitalisation data are available in the IMA-AIM database; however, no diagnostic information is recorded. Hospitalisations will therefore be categorised based on length of stay:

- Short-stay admissions: ≤ 3 days
- Longer admissions: > 3 days

Longer admissions may be more indicative of severe clinical deterioration associated with the ED and may therefore provide a more meaningful description of healthcare utilisation patterns.

Analyses of hospital admissions will be observational and descriptive. They will not constitute a formal evaluation of the effectiveness of the transversal care model and should not be interpreted as such. Instead, these analyses will provide contextual information that complements the implementation findings generated through the RE-AIM framework. They may also serve as a useful baseline for future evaluations.

In addition to hospitalisations, we will reconstruct and describe service users' healthcare trajectories over time. For this study, the patient journey is defined as the sequence of healthcare contacts and events experienced by a service user within the transversal care model. The analyses will examine aspects such as the timing of the first consultation with a dietitian or psychologist, patterns of engagement with different healthcare providers, the extent to which care is intensified during follow-up, and the timing and utilisation of more intensive forms of care, including day treatment programmes and residential hospitalisation.

The study population for these analyses will be identical to that used for the RE-AIM outcome analyses.

- **Epidemiological analyses regarding hospital stays**

For the epidemiological analyses based on the TCT and MPG-RPM databases, the study population will consist of children and young people aged 0 to 24 years with an ED recorded as either a principal or secondary diagnosis and who had at least one hospital admission between 2023 and 2025.

The study population will include: (i) service users with at least one admission to a psychiatric hospital; (ii) service users with at least one complete or partial stay in a PAAZ-SPHG; and (iii) service users with at least one admission to a non-psychiatric hospital ward during which an ED was recorded as a principal or secondary diagnosis.

Service users will be identified using the relevant ICD diagnostic codes for EDs recorded during the hospital stay. Age eligibility will be assessed at the time of the first admission recorded between 2023 and 2025. Once included, all subsequent hospital admissions occurring within the study period will also be taken into account.

The All Patient Refined Diagnosis Related Group (APR-DRG) classification associated with these hospitalisations, which is available only in the TCT database, may be used for descriptive and subgroup analyses. However, it will not be used as a primary inclusion criterion (see Appendix 5 for the relevant diagnostic codes).

5.2.3.4 Data analysis methods

DATA ANALYSIS IN GENERAL

As explained in Chapter 4, a robust effect evaluation is not feasible within the scope of this process evaluation study. Furthermore, because of the complexity of the intervention and the multidimensional nature of the RE-AIM framework, no clear hierarchy can be established among the different outcomes. Consequently, no formal study hypotheses have been formulated, and no ranking of outcomes according to importance will be applied. All analyses will therefore be descriptive. In line with this approach, p-values and confidence intervals will generally not be reported.

Continuous variables will be summarised using the following descriptive statistics: mean, median, standard deviation, range, and interquartile range (IQR). Where appropriate, continuous outcomes will also be visualised using boxplots.

Categorical variables will be summarised using frequencies and percentages for each category. Results will be presented both for the overall study population and for relevant subgroups.

Time-to-event variables will be analysed descriptively using Kaplan-Meier survival curves. Median event times will be reported where applicable. No formal statistical comparisons will be performed.

- **RE-AIM outcomes**

The outcomes defined within the RE-AIM framework, including outcomes derived from administrative databases (IMA-AIM) and questionnaires, are described in Chapter 4.

An important limitation concerns the use of pseudo-nomenclature codes related to part-time treatment programmes in both GGKJ-SMEA networks and ED reference centres. These codes are not linked to reimbursement and may therefore be combined with other reimbursable healthcare or psychological care services on the same day (Appendix 6). Because registration of these pseudo-nomenclature codes is not mandatory, their use may be incomplete, resulting in underreporting of the corresponding activities.

- **Service user-relevant outcome indicators**

Based on extracts from the IMA-AIM database, the following service user-relevant outcome indicators will be analysed:

  - Hospitalisations:
    - number and percentage of service users with at least one hospital admission, overall and by type of hospitalisation (internal medicine, psychiatry, paediatrics, other) and type of hospital;
    - number and percentage of service users with at least one short-stay hospital admission (≤ 3 days), overall and by type of hospitalisation and type of hospital;
    - number and percentage of service users with at least one longer hospital admission (> 3 days), overall and by type of hospitalisation and type of hospital;
    - number and percentage of service users with frequent hospital admissions (≥ 2, ≥ 3, etc.) within a one-year period, overall and by type of hospitalisation. For service users with an observation period exceeding one year, the maximum number of admissions within any consecutive 12-month period will be considered.
  - Length of stay per hospitalisation
  - Patient journey: patient journey, reconstructed through a flow chart describing the sequence of healthcare contacts and care transitions within the transversal care model.

In addition to the overall analyses, outcomes will be described for the following subgroups where relevant and feasible:

  - province/region;
  - age group: 10-14 years, 15-19 years, 20-24 years;
  - sex: female, male.

- **Epidemiological analyses regarding hospital stays**

Based on extracts from the TCT and MPG-RPM databases, the following epidemiological outcomes will be analysed for the period 2023-2025:

  - number of hospital admissions related to EDs;
  - number of service users with at least one hospital admission related to EDs;
  - type of hospital admission: referral-based versus own-initiative admission, emergency versus planned admission, day-care versus inpatient admission;

- length of hospital stay; and
- mortality.

In addition to the overall analyses, outcomes will be described for the following subgroups where relevant and feasible:

- province/region;
- age group: 10-14 years, 15-19 years, 20-24 years;
- sex: female, male;
- ED type: AN, BN, BED, OSFED;
- ED type combined with severity level;
- comorbidity profile: psychiatric and/or somatic comorbidities.

Data analysis in general

All statistical analyses will be performed using SAS software™ (SAS/BASE, SAS/STAT, and SAS/GRAPH), version 9.4 M5 for Microsoft (SAS Institute, Cary, NC, USA), and R version 4.3.3 or later. The specific R packages used for data management, statistical analyses, and visualisation will be documented in the final process evaluation report.

5.2.4 Questionnaires among service users and their parents or legal guardians

5.2.4.1 Key elements across different questionnaires

This component of the process evaluation uses cross-sectional questionnaires to assess the experiences of adolescents and young adults aged 10 to 24 years who are enrolled in intervention B (ED care pathway) or interventions D and F (part-time treatment programmes), as well as their parents or legal guardians. First, we outline the key elements shared by all questionnaires, including recruitment procedures, consent and assent processes, and data collection methods. Subsequently, we describe respondent-specific content, eligibility criteria, and the timeline for each questionnaire.

Consent and assent procedure

Respondents of the questionnaires will include both service users and parents or legal guardians (who complete a separate questionnaire), with different consent procedures applied:

- **Minor service users (respondents aged 10-15 years):**
  - Parents or legal guardians will first receive the study information and provide electronic informed consent. After parental consent is obtained, the parent or legal guardian will be asked to share the questionnaire link with their child.
  - The minor will receive written age-appropriate information and will be required to provide assent before accessing the questionnaire.
  - For minor service users, parents or legal guardians are also invited to complete a separate questionnaire focussing on their own experiences of the ED care pathway. The responses of parents/legal guardians and service users will not be linked in order to ensure and maximise participant anonymity and confidentiality. Given the relatively small and specific study population, linking responses could increase the risk of indirect identification, particularly when combining perspectives within a single care trajectory. In addition, keeping questionnaires unlinked encourages more open and honest reporting from both service users and their parents, as their responses cannot be traced back to one another.
- **Young adult service users (respondents aged 16-24 years) and/or parents or legal guardians:**

- Adult service users and/or parents/legal guardians will receive study information and provide electronic informed consent prior to questionnaire access.

Participation is voluntary for both minors and adults, and respondents may withdraw at any time without consequences for their care.

Data collection

Data will be collected using a secure online questionnaire platform. The questionnaires will be accessible on multiple devices (e.g. smartphones, tablets and computers). Separate but conceptually aligned questionnaire instruments will be used for service users and for parents or legal guardians, with overlapping domains where appropriate to allow triangulation of experiences. The questionnaires will be available in Dutch and French.

Adaptive questioning will be used to tailor the questionnaire to different age groups of the service users. No directly identifiable personal data will be collected. All responses will be stored in a pseudonymised or anonymised format.

Representativeness and accessibility considerations

Recruitment of service users and parents or legal guardians will be conducted through treating healthcare providers. To minimise the administrative burden on healthcare providers and reduce the risk of negatively affecting participation in the evaluation, no systematic registration of eligible individuals who decline participation will be performed. Consequently, it will not be possible to determine an exact response rate among all eligible participants, nor to analyse reasons for non-participation. However, the number of questionnaire invitations distributed by RIZIV-INAMI will be obtained and used as the denominator when calculating and reporting survey participation rates. While this will provide an indication of survey reach and uptake, it will not allow for a full assessment of eligibility among invitees or the reasons for non-participation. As a result, the representativeness of respondents cannot be fully assessed and the possibility of non-response bias should be considered when interpreting the questionnaire findings.

In addition, the questionnaires will only be available in Dutch and French. Consequently, service users, parents or legal guardians who do not have sufficient proficiency in one of these languages will not be able to participate in these components of the evaluation. This may result in an underrepresentation of families with other linguistic backgrounds and may limit insights into their experiences, needs, and potential barriers to care. The decision to restrict data collection to Dutch and French was made for feasibility reasons and to ensure the quality of the consent procedures, data collection, and analysis.

5.2.4.2 Questionnaires to assess experience of intervention B (ED care pathway)

Research objective

This component of the process evaluation study uses a cross-sectional questionnaire design to assess the experiences of adolescents and young adults aged 10 to 24 years who are currently enrolled in intervention B, as well as their parents.

SERVICE USERS ENROLLED IN INTERVENTION B

Recruitment procedure

To ensure that respondents can meaningfully reflect on their care experiences, only individuals who have been in intervention B for a sufficient period or early drop-outs (both defined below) will be eligible.

Eligible respondents will be identified by the physician who initiated their ED care pathway. These physicians will be contacted by RIZIV-INAMI via their eHealthBox and invited to support the

recruitment process.[w] To reduce the risk of duplicate response and limit patient burden, only the initiating physicians will be contacted. Participating physicians will receive standardised study materials, including a brief study description, eligibility criteria, instructions for recruitment, and invitation templates.

Physicians will then distribute questionnaire invitations to adolescents and young adults through their usual communication channels (e.g. email). For respondents under 16, the invitation will be sent to their parents or legal guardians instead.

Eligibility criteria

Respondents are eligible for inclusion if they meet all of the following criteria:

- aged between 10 and 24 years at the time of activation of intervention B;
- diagnosed with an AN, BN, BED and enrolled in intervention B;
- belonging to one of the following exposure groups:
    - Sufficient exposure group: (i) participation in intervention B for at least six months prior to recruitment or (ii) completion of intervention B, documented in the medical record within the past three months, after a minimum of six months of participation;
    - Early discontinuation group (early drop-outs): initiation of intervention B but discontinuation before six months of participation.

Respondents will be excluded if:

- intervention B was initiated less than 6 months prior to recruitment and is still ongoing;
- they are no longer reachable through the treating GP, paediatrician or psychiatrist;
- they or their parents/legal guardians are unable/unwilling to provide informed consent/assent
- they have insufficient proficiency in one of the questionnaire languages to complete informed consent/assent and the questionnaire.

Content questionnaire

The questionnaire content is aligned with the measures and indicators set out in Chapter 4. Where possible, items will be drawn from existing validated instruments, including validated language versions (French and/or Dutch) when available. In cases where validated translations are not available, a structured translation procedure will be applied, including forward translation, review, and cross-checking by bilingual experts to ensure conceptual equivalence and linguistic accuracy. Where necessary, items will be supplemented with newly developed questions created in collaboration with experts in child psychology from the Faculty of Psychology and Educational Sciences of the University of Ghent to ensure age-appropriate language and content. In addition, the developed questionnaire is pilot-tested with adolescents aged 10-14 years to assess the comprehensibility, clarity, and age-appropriateness of the questions. Feedback from this target group will be used to identify ambiguous wording and make any necessary revisions prior to data collection. The questionnaire will cover the following key domains:

- Sociodemographic characteristics: including age, gender, geographical location, educational status, living arrangements, occupation;
- Clinical and health-related characteristics: including ED diagnosis, age at diagnosis, comorbid physical and mental health conditions, and self-perceived physical and mental health status;

[w] eHealthBox is a secure electronic mailbox provided by the Belgian eHealth platform for the exchange of confidential medical information between healthcare stakeholders.

- Characteristics of the care pathway: including pathway initiation, referral source, healthcare providers involved, waiting times, number of contacts, treatment setting, and previous care received;
- Access to and organisation of care: including multidisciplinary care provision, care coordination, additional support services, treatment intensity, and time investment associated with care;
- Perceived experiences with the care pathway: including perceived impact on daily functioning, education, work, family life, social relationships, and leisure activities, as well as the extent to which care is tailored to individual circumstances;
- Communication, information provision, and shared decision-making: including the quality and consistency of information received, collaboration between care providers, respectfulness of interactions, and involvement in treatment decisions;
- Patient-reported outcomes and satisfaction: including perceived changes since pathway initiation, satisfaction with the content and intensity of care, and Net Promotor Score;
- Unmet need and improvement opportunities: including unmet care needs, barriers to accessing care, perceived priorities for improvement, and open-ended feedback regarding strengths and limitations of the care pathway.

QUESTIONNAIRE FOR PARENTS OR LEGAL GUARDIANS OF ADOLESCENTS AND YOUNG ADULTS ENROLLED IN INTERVENTION B

Design and population

In parallel with the service user questionnaire, a cross-sectional questionnaire will be conducted among parents or legal guardians of adolescents and young adults aged 10-24 years who are or have recently been enrolled in intervention B. This questionnaire aims to capture perspectives on access to care, coordination, communication with healthcare providers, and perceived impact of intervention B on the child and family.

Parents or legal guardians will be eligible independently of whether the adolescent or young adult chooses to participate.

Recruitment procedure

The recruitment procedure for parents or legal guardians will mirror that of the service user questionnaire. Physicians who initiated intervention B will be contacted to distribute parent-specific questionnaire invitations via their usual communication channels. Depending on standard practice, invitations may be sent directly to the parent or legal guardian, or indirectly via the child.

Eligibility criteria

Parents or legal guardians are eligible if:

- they are the parent or legal guardian of an adolescent or young adult aged 10-24 years enrolled in intervention B;
- the adolescent or young adult belongs to one of the following exposure groups:
    - Sufficient exposure group: (i) participation in intervention B for at least six months prior to recruitment or (ii) completion of intervention B, documented in the medical record within the past three months, after a minimum of six months of participation;
    - Early discontinuation group (early drop-outs): initiation of intervention B but discontinuation before six months of participation.
- Parents or legal guardians will be excluded if:
    - they are unable or unwilling to provide informed consent;
    - they have insufficient proficiency in one of the questionnaire languages.

Content questionnaire

The parent questionnaire mirrors the service user questionnaire with respect to the assessment of:

- Clinical characteristics of the ED;
- Characteristics of the care pathway (e.g. pathway initiation, healthcare providers involved, waiting times, treatment setting and intensity, and previous care received);
- Perceived experiences with care delivery, organisation, communication, information provision, care coordination and involvement in decision-making;
- Unmet care needs, barriers to accessing care, priorities for improvement, and overall satisfaction with the ED care pathway.

In addition, the parent/legal guardian includes several domains that are specific to the parental perspective:

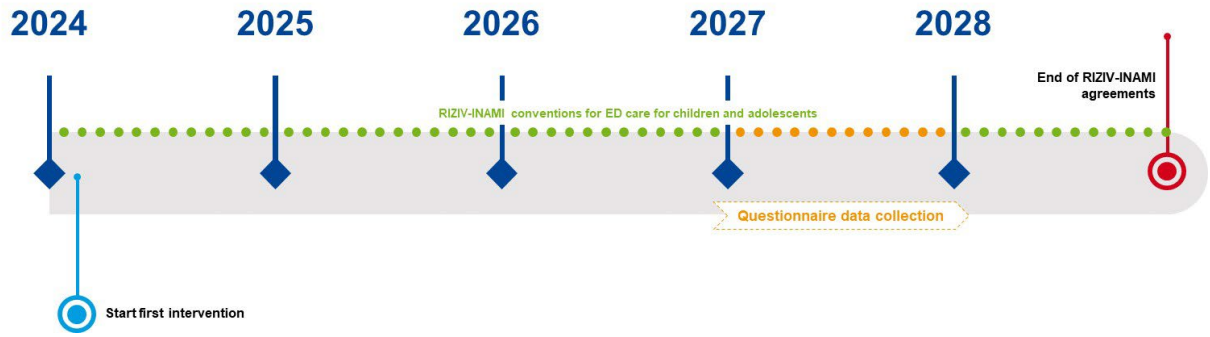
- Parent and household characteristics: including gender, educational attainment, employment status, relationship to the child, household composition, and family circumstances;
- Child and family context: including the child's living arrangement, school situation, health insurance coverage, and relationship with the responding parent or guardian;
- Parental experiences and involvement: including the extent to which parents receive information, are listened to by healthcare providers, are involved in treatment decisions, and perceive their child to be encouraged to participate actively in the care;
- Impact of the care pathway on family life: including consequences for parental employment, time spent coordinating and supporting care, perceived impact on parents' physical and mental health, social life, and family relationships;
- Parent-reported impact on the child: including perceived effects of the care pathway on school functioning, peer relationships, and self-esteem.

Timeline

Recruitment and data collection of both questionnaires for intervention B will start at the earliest feasible time following approval by the Ethics Committee and the completion of the online questionnaire programming. Subject to these prerequisites being met as planned, recruitment is anticipated to start in January 2027 (Figure 8). Healthcare providers will invite respondents during routine care interactions or via email, allowing sufficient opportunity for participation and questionnaire completion, particularly in view of the two-step consent process required for minors.

Preparatory activities, including ethics approval and development of study materials, will occur prior to the recruitment period and are not included in this timeline. Data collection will remain open throughout 2027 and will close at the end of December 2027. Following closure of the questionnaires, the data dataset will undergo cleaning and analysis.

Figure 8 – Timeline for questionnaire data collection among service users and parents/legal guardians



Note: each green dot represents a month.

5.2.4.3 Questionnaires to assess experience of interventions D or F (part-time treatment programmes)

Research objective

This component will also utilise a cross-sectional questionnaire design to assess the experiences of service users aged 10 to 24 years diagnosed with an ED and enrolled in intervention D or F, as well as their parents or legal guardians.

Two types of part-time treatment programmes will be considered:

- Intervention D: ambulatory part-time treatment programmes organised by the GGKJ-SMEA networks, including MFT sessions
- Intervention F: part-time treatment programmes delivered within ED reference centres, including iMFT sessions

To ensure that respondents can meaningfully reflect on their care experiences, only individuals with sufficient exposure (defined below) to the programme will be eligible. Eligible respondents will be identified through the treatment teams responsible for the part-time programmes.

FEASIBILITY SAFEGUARD

Prior to initiating recruitment, the feasibility of this component will be assessed using implementation numbers from preliminary data received from RIZIV-INAMI. This safeguard is informed by the preliminary analysis of the 2025 annual activity reports, which indicated that five of the eleven GGKJ-SMEA networks had not yet launched their ambulatory part-time treatment programmes and that enrolment in operational programmes remained limited (3-14 patients per programme). These findings suggest that implementation was still at an early stage in many networks and raise concerns about the availability of a sufficiently large and diverse respondent sample.

Therefore, the feasibility of this questionnaire component, including both service user and parent/legal guardian questionnaires, will be reviewed jointly with the commissioners on 31 January 2027. The component will only be conducted if a minimum level of uptake of these interventions is observed. Specifically, at least five participating networks with a minimum of 20 included service users per network who initiated the part-time treatment programme are required. This threshold is to ensure sufficient variability across settings and support meaningful analysis.

If this threshold is not reached, this component of the process evaluation will not be conducted. Instead, focus group discussions will be undertaken at participating sites to explore barriers to implementation, understand the factors underlying incomplete adoption, and examine whether

these factors indicate implementation challenges or concerns regarding the fit and feasibility of the interventions within the transversal care model. Findings will inform potential adaptations to implementation strategies and, where relevant, considerations regarding the continued inclusion of specific interventions in the care model. This approach balances the need for valid and representative results with feasibility constraints, resource requirements, and the risk of biased or underpowered samples.

QUESTIONNAIRE OF SERVICE USERS ENROLLED IN INTERVENTION D OR F

Recruitment procedure

Participating sites will be contacted and invited to support recruitment. Treatment teams will receive standardised study materials, including a brief study description, eligibility criteria, instructions for recruitment, and invitation templates.

Questionnaire invitations will be distributed via usual communication channels with the service users and/or their parents.

Eligibility criteria

Respondents are eligible for inclusion if they meet all the following criteria:

- aged between 10 and 24 years at the time of initiation of intervention D or F;
- diagnosed with an AN, BN, or BED and enrolled in intervention D or F, or diagnosed with OSFED and enrolled in intervention F;
- have had sufficient exposure to the intervention to provide informed and meaningful reflections. This is defined as either:
    - currently being in the final phase of the intervention's scheduled duration (e.g. the last two weeks prior to the planned discharge), or
    - having completed the intervention within the past three months at the moment of recruitment.

Respondents will be excluded if:

- intervention D or F was initiated less than three months prior to recruitment;
- they are no longer reachable through the treatment team;
- they or their parents/legal guardians are unable to provide informed consent/assent
- they have insufficient proficiency in one of the questionnaire languages to complete informed consent/assent and the questionnaire.

Content questionnaire

The questionnaire content is aligned with the measures and indicators set out in Chapter 4. Where possible, items will be drawn from existing validated instruments, including validated language versions (French and/or Dutch) when available. In cases where validated translations are not available, a structured translation procedure will be applied, including forward translation, review, and cross-checking by bilingual experts to ensure conceptual equivalence and linguistic accuracy. Where necessary, items will be supplemented with newly developed questions created in collaboration with experts in child psychology from the Faculty of Psychology and Educational Sciences of the University of Ghent to ensure age-appropriate language and content. In addition, the developed questionnaire will be pilot-tested with adolescents aged 10-14 years to assess the comprehensibility, clarity, and age-appropriateness of the questions. Feedback from this target group will be used to identify ambiguous wording and make any necessary revisions prior to data collection.

The questionnaire largely builds upon the service user questionnaire for the ED care pathway (intervention B, see section 5.2.4.2) and covers similar domains, including:

- sociodemographic characteristics;
- clinical and health-related characteristics;
- experiences with care delivery, organisation, communication, information provision, care coordination and shared decision-making;
- perceived impact of care on daily functioning and social participation;
- patient satisfaction, perceived outcomes, unmet needs, barriers to care, and suggestions for improvement.

Questions were adapted to specifically refer to the part-time treatment programmes. In addition, the questionnaire includes several part-time programme-specific domains:

- Characteristics of the part-time treatment programme: including date of programme initiation, referring healthcare provider, treatment centre, healthcare providers involved, weekly treatment intensity, and previous care received before programme enrolment;
- Access to the programme: including waiting time between referral and initiation of treatment;
- Programme-specific treatment components: satisfaction with the content and intensity of the part-time treatment programme and, where applicable, satisfaction and frequency of MFT sessions;

Similar to the service user questionnaire for the ED care pathway (intervention B), participants were also invited to provide open-ended feedback on strengths, limitations, unmet needs, and opportunities for improvement of the programme.

QUESTIONNAIRE PARENTS OR LEGAL GUARDIANS OF SERVICE USERS ENROLLED IN INTERVENTION D OR F

Recruitment procedure

The recruitment procedure for parents or legal guardians will mirror that of the service user questionnaire. Participating sites will be contacted and invited to support recruitment. Parents or legal guardians will be invited to complete a separate questionnaire focusing on their own experiences with intervention D or F, independent of whether the adolescent or young adult participates.

Eligibility criteria

Parents or legal guardians are eligible if:

- they are the parent or legal guardian of an adolescent or young adult aged 10-24 years enrolled in intervention D or F;
- the adolescent or young adult meets the intervention exposure criteria described above.

Parents or legal guardians will be excluded if they are unable or unwilling to provide informed consent or if they have insufficient proficiency in one of the questionnaire languages.

Content questionnaire

The parent/legal guardian questionnaire will be conceptually aligned with the service user questionnaire while focusing on caregiver-specific perspectives. It will assess experiences with the intervention from the viewpoint of parents or legal guardians. This questionnaire largely mirrors the parent/legal guardian questionnaire used to evaluate the ED care pathway (intervention B).

As the content and measurement of these domains largely correspond to those described for the parent/legal guardian questionnaire in the context of the ED care pathway, they are not repeated here. Questions were adapted to specifically refer to the part-time treatment programme. In addition, the

questionnaire assessed several aspects specific to the part-time treatment programme, mirroring the programme-specific questions included in the service users questionnaire.

Timeline

The same recruitment procedure and data collection timeline as described for intervention B will be followed for intervention D and F (see section 5.2.4.2). Recruitment and data collection will commence at the earliest feasible time following Ethics Committee approval and completion of the survey programming and testing phase, with data collection anticipated to start in January 2027. Delivering care organisations will invite eligible respondents during routine care interactions or via email. Data collection will remain open throughout 2027 and will close on 31 December 2027, after which the data will be cleaned and analysed.

5.2.5 Questionnaires among healthcare providers

In addition to the questionnaires collected among service users and their parents or legal guardians across different interventions, a cross-sectional questionnaire will also be implemented to assess the experiences of healthcare providers involved in intervention B. This questionnaire aims to explore healthcare providers' perspectives on the implementation, accessibility, coordination, feasibility, and perceived added value of intervention B in routine clinical practice.

The questionnaire will specifically target the main professional groups involved in intervention B, including:

- physicians (e.g. GPs, paediatricians, psychiatrists);
- dietitians;
- psychologists or educational therapists.

The findings will complement the perspectives collected from service users and parents or legal guardians and will contribute to a comprehensive evaluation of intervention B across stakeholders.

HEALTHCARE PROVIDER QUESTIONNAIRE FOR INTERVENTION B

Recruitment procedure

Healthcare providers involved in intervention B will primarily be identified through RIZIV-INAMI administrative records and invited to participate via their eHealthBox. To maximise study reach and participation, the survey invitation will also be disseminated through mailing lists and newsletters of relevant professional associations and networks of physicians, dietitians, and psychologists, and participating GGKJ-SMEA networks and ED reference centres. These additional channels are intended to increase awareness of the process evaluation study and encourage participation among eligible healthcare providers.

Potential respondents will receive a standardised study invitation containing a brief description of the study objectives, eligibility criteria, information regarding voluntary participation and confidentiality, a secure link to the online questionnaire.

To maximise participation across professional groups and care settings, reminder invitations may be distributed during the recruitment period through the same communication channels.

Eligibility criteria

Respondents are eligible for inclusion if they meet all the following criteria:

- currently working as a physician (e.g. GP, paediatrician, psychiatrist), psychologist/educational therapist, or dietitian;
- directly involved in the care of children or young people enrolled in intervention B;
- have experience with at least one patient enrolled in intervention B during the evaluation period;

- able and willing to provide informed consent.

Respondents will be excluded if they have not been involved in intervention B, are unable or unwilling to provide informed consent, have insufficient proficiency in one of the questionnaire languages to complete informed consent and the questionnaire.

Consent procedure

All participating healthcare providers will receive study information electronically and will be required to provide electronic informed consent before accessing the questionnaire.

Participation will be voluntary, and respondents may discontinue participation at any time without consequences.

Data collection

Data will be collected through a secure online questionnaire platform. The questionnaire will be available in Dutch and French.

No directly identifiable personal data will be collected. Responses will be stored in a pseudonymised or anonymised format.

To reduce respondent burden, adaptive questioning will be used so that respondents only receive questions relevant to their professional role and experience with intervention B.

Content questionnaire

The questionnaire content will be aligned with the measures and indicators outlined in Chapter 4 and will focus on the implementation and functioning of intervention B from the perspective of healthcare providers.

The questionnaire will cover the following key domains:

- experiences with activation and implementation of intervention B;
- perceived accessibility and appropriateness of the care pathway;
- interdisciplinary collaboration and coordination of care;
- communication between healthcare providers involved in the pathway;
- clarity of roles and responsibilities within the care pathway;
- perceived impact of intervention B on continuity and quality of care;
- perceived benefits and challenges of the intervention;
- administrative and organisational burden;
- perceived barriers and facilitators to implementation;
- suggestions for improvement and sustainability of intervention B.

In addition to closed-ended questions, optional open-ended questions will allow healthcare providers to elaborate on their experiences and provide recommendations for future optimisation of the care pathway.

Timeline

Recruitment and data collection for the healthcare provider questionnaire will follow the same procedure and timeline as outlined for intervention B (see section 5.2.4.2). Following Ethics Committee approval and completion of the survey programming and testing phase, data collection is anticipated to commence in January 2027. The questionnaire will be administered in parallel with the questionnaires for service users and parents or legal guardians. Data collection will remain open throughout 2027 and will close on 31 December 2027. Following questionnaire closure, the data will be cleaned, validated, and analysed.

5.3 Qualitative data collection methods and analysis

5.3.1 Introduction

To gain insight into the implementation of the interventions, their underlying mechanisms, facilitating and hindering factors, and the influence of contextual elements, a qualitative data collection component will be conducted among:

- Providers of interventions in the transversal ED care model: (i) the GGKJ-SMEA networks; (ii) the ED reference centres, and (iii) hospitals within the GGKJ-SMEA networks providing part-time treatment programmes;
- ED service users and their parents or legal guardians.

5.3.2 Focus group discussions with providers of interventions

As mentioned above, three different types of focus group discussions will be organised as part of this section of the qualitative component:

- focus group discussions with representatives of **GGKJ-SMEA networks**;
- focus group discussions with representatives of **ED reference centres**; and
- focus group discussions with representatives of **hospitals within the GGKJ-SMEA networks** providing intervention D.

5.3.2.1 Recruitment procedure

Participants will be recruited using purposive expert sampling. Invitations will be distributed via email through the designated contact person of each organisation listed at RIZIV-INAMI. These contact persons will be asked to delegate one or two representatives with relevant expertise. Where feasible, organisations will be encouraged to delegate participants with complementary roles and perspectives relevant to the organisation and implementation of the intervention(s) under discussion. Participation will be voluntary.

- Focus group discussions with GGKJ-SMEA networks: all 11 GGKJ-SMEA networks will be invited to delegate representatives with expertise in the organisation and implementation of intervention A, C and/or D in the transversal care model for EDs.
- Focus group discussions with ED reference centres: all nine reference centres will be invited to delegate representatives with expertise in the organisation and implementation of intervention E and/or F.
- Focus group discussions with hospitals within the GGKJ-SMEA networks providing intervention D: all hospitals within the GGKJ-SMEA networks that provide part-time treatment programmes (and that are not ED reference centres) will be invited to delegate representatives with relevant expertise in the organisation and implementation of intervention D.

FEASIBILITY SAFEGUARD

Before initiating recruitment for the focus group discussions with hospitals providing intervention D within GGKJ-SMEA networks, the feasibility of this component will be assessed using preliminary implementation data received from RIZIV-INAMI. The feasibility of this component will be reviewed jointly with the commissioners on 31 January 2027. These focus groups will only be conducted if a minimum level of uptake of this intervention is observed. Specifically, at least five participating networks with a minimum of 20 service users should be enrolled in intervention D.

If this threshold is not reached, this component of the process evaluation will not be conducted. Instead, focus group discussions with the GGKJ-SMEA networks will be conducted to explore barriers to implementation, understand the factors underlying incomplete adoption, and examine whether these factors indicate implementation challenges or concerns regarding the fit and feasibility of the interventions within the transversal care model. Findings will inform potential adaptations to implementation strategies and, where relevant, considerations regarding the continued inclusion of specific interventions in the care model. This approach balances the need for valid and representative results with feasibility constraints, resource requirements, and the risk of biased or underpowered samples.

5.3.2.2 Data collection procedure and tools

Data will be collected through six semi-structured focus group discussions conducted by members of the research team. For each of the three focus group types, two sessions will be organised: one Dutch-speaking and one French-speaking, each moderated by a native speaker. This approach ensures linguistic homogeneity within groups, facilitating interaction and enhancing data quality. Depending on feasibility and participant availability, sessions will take place either online or in person and will last a maximum of two hours. With participants' consent, focus groups will be audio-recorded and transcribed verbatim to support analysis. As mentioned above, one or two representatives per organisation will be invited to participate. The number of participants per group will be monitored during recruitment to ensure that group sizes remain conducive to effective interaction and moderation. If necessary, participation will be limited to one representative per organisation or additional focus group sessions will be organised. Six focus group discussions are planned based on the principle of information power, the specificity of the participant groups, and the evaluation study context.[92] The adequacy of the sample will be assessed iteratively during data collection and analysis, and the number of focus groups may be adjusted if the information power of the data is considered insufficient or if the quality and richness of the discussions warrant additional sessions.

Box 11 – Key considerations for focus group composition and facilitation

Focus groups are typically composed of participants who are relatively homogenous in relation to key characteristics relevant to the research focus. In line with the KCE process notes on qualitative research methods, unilingual groups are recommended, as they facilitate clearer communication and more effective moderation. For face-to-face focus groups, the ideal size is eight to ten participants. For online focus groups, smaller group sizes of approximately five to six participants are advised, given that interaction and facilitation can be more challenging in a virtual setting.[93]

For each type of focus group, a generic interview guide will be developed covering key topics such as:

- Perceived facilitators and barriers
- Collaboration between stakeholders
- Contextual influences
- Sustainability of the interventions

- Perceived added value of the initiatives
- Necessary actions for improvement of the current system

To support effective participation, a brief overview of the main discussion themes and focal points will be shared with participants in advance, without providing the full interview guide.

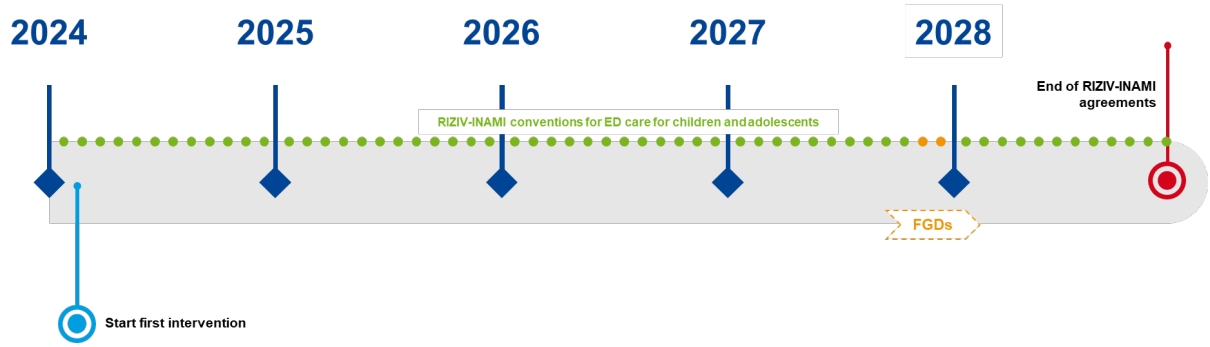
These guides may be slightly adjusted based on information or preliminary findings emerging during the evaluation period (late 2026-early 2028) of the transversal care model. All interview guides are available upon request.

Timeline

The focus group discussions will be conducted in November and December 2027 (Figure 9). This timing was selected to ensure that participants can draw on a substantial period of implementation experience and provide insights based on the most up-to-date information available regarding the organisation and delivery of the interventions. It also allows participating organisations sufficient time to further develop, implement, and embed interventions that are currently still being operationalised.

At the same time, this timeframe leaves sufficient time for the transcription, analysis, and interpretation of the qualitative data before preparation of the final evaluation report.

Figure 9 – Timeline focus group discussions with providers of interventions



Note: each green dot represents a month.

FGDs: focus group discussions

5.3.3 Individual interviews with service users and parents or legal guardians

In addition to the focus groups, individual interviews will be conducted with service users of the ED care interventions foreseen in the transversal care model and their parents or legal guardians. These interviews aim to capture personal experiences and perspectives that may be more sensitive or detailed than those surveyed in the questionnaires. By enabling an in-depth exploration of individual care journeys, interviews provide insights into how interventions are experienced in practice, including aspects that may not be captured within the structured format of predefined survey questions. This qualitative approach allows participants to speak freely about their experiences and ensures that the views of both service users and their families are adequately represented in the process evaluation. Furthermore, the qualitative data will complement and enrich the quantitative findings by providing context and nuance, thereby supporting a more comprehensive interpretation of the overall results.

5.3.3.1 Recruitment procedure and sampling strategy

Participants will be recruited through an opt-in mechanism integrated at the end of the quantitative questionnaires (see section 5.2.4). Respondents will be asked whether they are willing to participate in a follow-up interview and, if so, to provide contact details. Those who consent to be contacted will be subsequently approached by the research team via email or telephone and invited to participate.

For minor respondents, additional steps are required to ensure appropriate consent procedures. Minors who express willingness to participate will be asked to provide the contact information (email address and/or telephone number) of their parent or legal guardian, who will be contacted to provide informed consent for participation in the interview.

Participants in the individual interviews will be stratified by age, with different consent procedures applied:

- **Minor service users (respondents aged 10-15 years):**
  - Parents or legal guardians will first receive the study information and provide electronic informed consent.
  - After parental consent is obtained, the minor will receive written age-appropriate information and will be required to provide assent prior to the interview.
- **Young adult service users (respondents aged 16-24 years) and parents or legal guardians:**
  - Respondents will receive study information and provide electronic informed consent prior to the individual interview.

Participation is voluntary for both minors and adults, and respondents may withdraw at any time without consequences for their care.

Recruitment will continue until sufficient variation across key characteristics is achieved. A purposive sampling strategy will be used to ensure a heterogeneous sample that captures a broad range of experiences. Participants will be selected based on the following dimensions:

- Age groups: 10-13 years, 14-17 years, and 18-24 years
- Type of care received: intervention D, intervention F, and/or enrolled in an (i)MFT programme.[x]

The sampling framework consists of six strata defined by combinations of age group and care trajectory. Within each stratum, four participants will be selected, resulting in a total sample of 24 individual interviews (see Table 25).

Table 25 – Sampling matrix individual interviews

Age group	Intervention D Part-time treatment programme GGKJ-SMEA + MFT	Intervention F Part-time treatment programme ED reference centre + iMFT	Subtotal interviews
10-13 years	2 NL 2 FR	2 NL 2 FR	**8**
14-17 years	2 NL 2 FR	2 NL 2 FR	**8**
18-24 years	2 NL 2 FR	2 NL 2 FR	**8**
Total strata	**12**	**12**	**24**

Each sampling cell includes one service user interview and one parent/legal guardian interview. These interviews are not necessarily conducted with related individuals. Therefore, each sampling cell represents two interviews. NL: ISO language code for Dutch; FR: ISO language code for French

[x] We focus specifically on participants involved in part-time treatment programmes (GGKJ-SMEA or ED reference centres) and (i)MFT interventions, as in practice service users entering these interventions are typically required to be enrolled in the ED care pathway under the RIZIV-INAMI agreement.

For each language group (Dutch and French), two participants will be recruited: one adolescent or young adult with an ED and one parent or legal guardian. Participants will be sampled independently and will not necessarily be related to one another. This approach allows for the inclusion of both service user and caregiver perspectives across the sample while maintaining feasibility. Efforts will be made to achieve an overall balance between participant types across the dataset (in terms of ED diagnosis, participation in (i)MFT sessions). In exceptional cases, a service user and their parent/legal guardian may both be interviewed; however, recruiting participants from different families is preferred to maximise diversity in experiences and perspectives. Additionally, linguistic balance will be ensured by including an equal number of Dutch- and French-speaking participants (n=12 per language group).

This sampling approach prioritises maximal variation across key structural dimensions, while capturing both service user and caregiver perspectives across the dataset. Furthermore, participants will be selected to reflect diversity across the main diagnostic categories covered by the transversal care model for EDs, namely AN, BN, and BED.

FEASIBILITY SAFEGUARD

As the individual interviews rely on an opt-in mechanism embedded within the quantitative questionnaires, they will only be conducted if this questionnaire component is implemented. If the feasibility threshold for the part-time treatment programmes for the quantitative component is not met (see section 5.2.4.3), individual interviews will not take place. Instead, the process evaluation will focus solely on the focus group discussions with participating providers to explore barriers to implementation and to better understand why these interventions are not being fully adopted. This approach aims to balance the need for valid and representative results with feasibility constraints and resource considerations.

5.3.3.2 Data collection procedure and tools

Data will be collected through semi-structured individual interviews conducted by trained researchers with experience in qualitative methods and working with vulnerable populations. Interviews with minors will usually take place without a caregiver or confidential person present, as this is expected to encourage more open and honest responses and reduce social desirability bias. However, if a minor prefers to have a caregiver or confidential person present, this will be allowed to ensure their comfort and sense of safety throughout the interview.

The interview guide is aligned with the measures and indicators set out in Chapter 4 and is developed separately for each participant group (service users and parents/legal guardians). Interview guides are developed in collaboration with experts in child psychology from the Faculty of Psychology and Educational Sciences of the University of Ghent to ensure age-appropriate language and content.

Key topics during these interviews are:

- Experience with the intervention
- Perceived accessibility and coordination of care
- Perceived facilitators and barriers to care
- Impact of treatment on daily life and wellbeing
- Recommendations for improving ED-related healthcare services

The interview guides will allow flexibility to probe emerging themes and adapt to participant responses. All interview guides are available upon request.

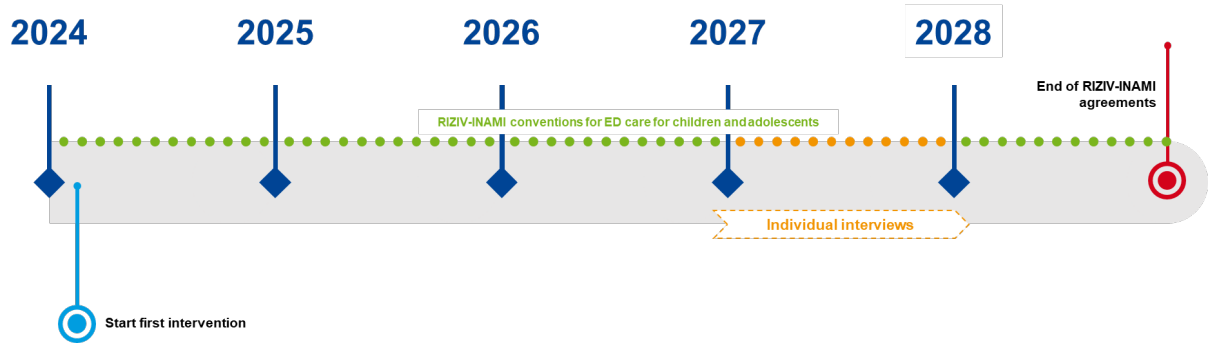
Interviews will be conducted online via secure video conferencing. Interviews with young people are expected to last approximately 30-45 minutes, while interviews with parents are expected to last approximately 45-60 minutes. These durations are intended to balance the depth of the interview with participant burden and feasibility. The duration will remain flexible and may be adapted depending on

the participant's willingness and the depth of the discussion. With participants' consent, interviews will be audio-recorded.

Timeline

Qualitative interviews with service users and with parents or legal guardians will be conducted in parallel with the questionnaire data collection. Recruitment is expected to begin in January 2027, following Ethics Committee approval and implementation of the electronic questionnaires. Respondents who complete the questionnaire and indicate their willingness to participate in a follow-up interview will be invited for an individual interview. Purposive sampling will be applied using the predefined selection matrix (Table 25). Potential interview participants will be contacted on an ongoing basis throughout the questionnaire data collection period, and recruitment will continue until the predefined selection criteria have been fulfilled. While questionnaire data collection will close on 31 December 2027, recruitment and scheduling of qualitative interviews will remain open until 31 January 2028 to allow sufficient time for arranging and conducting interviews with respondents who expressed an interest in participating near the end of the questionnaire period (Figure 10). Following completion of the interviews, audio recordings will be transcribed, anonymised, and analysed using qualitative data analysis methods.

Figure 10 – Timeline individual interviews with service users and parents/legal guardians



Note: each green dot represents a month.

5.3.4 Data-analysis and reporting

Interviews and focus groups will be analysed using the Framework Method, using NVivo software.[94] A semi-inductive approach will be adopted, whereby themes will be identified from the data while also being informed by relevant implementation science concepts. This approach allows for systematic comparison across participating organisations and facilitates integration with quantitative implementation indicators.[94]

First, one researcher will familiarise themselves with the data and develop an initial analytical framework based on a subset of transcripts selected to ensure a broad range of perspectives across participating organisations and respondent groups. The analytical framework will be informed by the study objectives and emerging findings from the data, while remaining sufficiently flexible to capture unanticipated themes. Where relevant, the Consolidated Framework for Implementation Research (CFIR) will be used as a sensitising framework to support the identification and organisation of implementation-related factors.[y 95-97]

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y CFIR is a widely used implementation science framework that helps identify and understand factors influencing the successful implementation of interventions or innovations. It brings together constructs from multiple implementation theories into a comprehensive framework that can be used to explore barriers and facilitators across different contexts and settings. The framework is organised into several domains, including characteristics of the intervention, the inner and outer setting, the individuals involved,

Subsequently, two researchers, one French-speaking and one Dutch-speaking, will independently apply and refine the analytical framework while coding the remaining transcripts. Coding decisions and modifications to the framework will be discussed iteratively until agreement is reached. To ensure consistency across languages, coding will take place in the original language of the transcript whenever possible, using a shared coding framework and regular cross-language discussions between researchers.

Once coding is completed, data will be summarised in a framework matrix that enables systematic comparison across organisations, GGKJ-SMEA networks, or ED reference centres. The matrix will be used to identify patterns, similarities, differences, and relationships within and between cases. Where feasible, thematic patterns will also be compared between organisations with relatively high and relatively low uptake of the interventions, based on available implementation data. This comparative analysis will explore whether variations in implementation experiences, contextual factors, barriers, facilitators, and collaboration mechanisms may help explain differences in intervention uptake. Given the expected number of participating organisations, these comparisons will be considered exploratory in nature.

Findings from the interviews and focus groups will be illustrated using selected verbatim quotations in Dutch or French. Where necessary, quotations will be translated into the language of the evaluation report, with the original meaning preserved through discussion among bilingual members of the research team. For each quotation, the respondent profile or perspective will be reported while maintaining participant confidentiality and anonymity.

5.4 Ethical, regulatory and data protection considerations

5.4.1 IVC-CSI application

As described in section 5.2.3, data from the IMA-AIM, EPS, TCT, MPG-RPM, and Doc N databases will be requested for the quantitative analysis of administrative data.

For individual-level data from IMA-AIM and MPG-RPM, prior approval from the Information Security Committee (IVC-CSI) is required and will be obtained before data access is requested. EPS and TCT data are directly available to KCE. The Doc N database contains only non-personal, aggregated data (at the billing code and calendar-year level) and is therefore also directly accessible to KCE.

5.4.2 Ethical committee application

The evaluation study protocol for the different components will be submitted to a Belgian Medical Ethics Committee for review and approval prior to the start of the data collection. Any amendments or recommendations provided by the Ethics Committee will be incorporated into the protocol where applicable. Consequently, the current protocol may be subject to modifications following the ethical review process.

All study procedures will be conducted in accordance with applicable ethical standards for research involving human participants. Participants will be informed about the objectives of the process evaluation study, the voluntary nature of participation, and the handling of their data before providing informed consent.

5.4.3 Data protection

All personal data collected and analysed within the framework of this evaluation will be processed in compliance with the Belgian law of 30 July 2018 and with the European Regulation 2016/679 concerning the protection of natural persons with regard to the processing of personal data.

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and the implementation process. CFIR can support the systematic organisation, analysis, and interpretation of qualitative data related to implementation processes and outcomes.

Data will be processed solely for the purposes of this evaluation and will only be accessible to authorised members of the research team. Appropriate technical and organisational measures will be implemented to ensure the confidentiality, integrity, and secure storage of the data. Whenever possible, data will be pseudonymised or anonymised prior to analysis and reporting. Any reporting of results will occur at an aggregated level to prevent the identification of individual participants.

6 CONCLUSION

The transversal care model for children and young people with EDs represents an important policy initiative aimed at strengthening early detection, improving access to multidisciplinary care, enhancing coordination across providers and care settings, and reducing reliance on more intensive forms of treatment. Since its introduction, the model has been implemented through a set of six interconnected core components that operate across different levels of care and organisational settings.

As demonstrated throughout this protocol, the complexity of the transversal care model, combined with its phased implementation in routine practice, presents important methodological challenges for evaluation. The absence of pre-implementation baseline data, the lack of suitable comparison groups, and the heterogeneity in intervention delivery limit the feasibility of conducting a robust effect evaluation. Consequently, this evaluation study protocol focuses primarily on **process evaluation**, with specific attention to implementation, perceived effectiveness, mechanisms of change, and contextual factors influencing the functioning of the interventions.

To address these objectives, a **mixed-methods approach** will be applied, combining annual activity reports, administrative databases, questionnaires among service users, parents or legal guardians, and healthcare providers, as well as qualitative interviews with service users and their parents and focus group discussions with healthcare providers/organisations. The integration of these complementary data sources will enable an understanding of how the interventions are implemented in practice, how they are experienced by stakeholders, and which factors facilitate or hinder their successful delivery.

A limitation of the proposed evaluation is that the perspectives of individuals who remain outside the care system are largely beyond the reach of this evaluation. This includes people with ED-related care needs who never reach a healthcare provider, do not enter specialised care pathways, or remain disconnected from available services. Consequently, accessibility can only be assessed to a limited extent from the perspective of individuals who successfully access and engage with the transversal care model. Future evaluations may consider targeted recruitment strategies to better capture the experiences of individuals who do not enter the care system and the barriers that prevent access to care.

The findings of the process evaluation will provide policymakers, commissioners, healthcare organisations, and professionals with evidence on implementation challenges, examples of good practice, opportunities for improvement, and conditions required for sustainable implementation. Although the present process evaluation protocol is not designed to determine the effectiveness of the interventions, it will generate valuable insights into how the care model operates in real-world settings and how its implementation can be strengthened or adapted in the future.

Following completion of the analyses, the preliminary findings and draft recommendations will be discussed with relevant stakeholders, including organisations involved in the implementation of the care model and professional associations. In line with the standard KCE study procedure, this stakeholder consultation forms an integral part of the validation and development of the recommendations. It aims to support the interpretation of the findings, assess the relevance, acceptability, and feasibility of the proposed recommendations, and facilitate their translation into future policy and practice.

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