

EMPIRICALLY GROUNDED CLINICAL GUIDANCE PAPER

Equitable access to evidence-based treatment for eating disorders for patients with low-income: identifying barriers and exploring solutions

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(Received 12 June 2023; revised 27 December 2023; accepted 3 January 2024)

Abstract

Eating disorders are equally prevalent across socioeconomic status, and yet individuals facing socioeconomic adversity are far less likely to receive evidence-based treatments. A range of barriers contribute to this disparity, including limited awareness and provider training about eating disorders leading to underdiagnosis; a shortage of available services and long waitlists due to a lack of trained therapists, associated treatment costs (e.g. transportation expenses and costly treatment materials) and an insufficient understanding of the impact of an individual's cultural context. While these barriers are experienced by many individuals with eating disorders, those with low income are particularly vulnerable. To ensure equitable access to effective eating disorder treatment, therapists should actively consider and address the barriers faced by these patients. In this paper, we share guidance based on our experience treating a socioeconomically diverse patient population, on factors to consider when extending the reach of recommended psychological treatments for eating disorders and suggest areas of future research. We emphasize the opportunities available to therapists to improve equity in eating disorders treatment by making accommodations that enhance access to existing evidence-based approaches rather than by making modifications to the treatments.

Key learning aims

- (1) To identify obstacles experienced by individuals with eating disorders and low income in accessing and engaging in treatment.
- (2) To learn practical strategies to reduce or eliminate barriers preventing the uptake of evidence-based psychological eating disorder interventions for individuals with low income.
- (3) To appreciate the intersectionality of low income with other factors impacting equity of eating disorder treatment access.

Keywords: Dissemination; Eating disorders; Equity; Low income; Treatment access; Treatment barriers

Introduction

Eating disorders (EDs) are complex psychiatric illnesses affecting up to 4% of the population, with serious implications for morbidity and mortality (Arcelus *et al.*, 2011; Iwajomo *et al.*, 2021). They are associated with numerous medical complications and elevated levels of psychological distress

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and reduced quality of life (van Hoeken and Hoek, 2020). Individuals with EDs are at heightened risk for early death, and age at assessment of the disorder has been found to be a predictor of mortality in those with restrictive EDs (Fichter and Quadflieg, 2016). In addition to grave costs to individuals, EDs are extremely financially costly. In the United States (US), for example, a recent cost-of-illness study estimated the annual health care cost of EDs at \$64.7 billion, roughly \$11,800 per affected individual (Streatfeild *et al.*, 2021). Furthermore, EDs have a remarkably high global burden of disease, and in recent decades, the burden estimates have increased within low- and middle-income countries (Erskine *et al.*, 2016).

Fortunately, EDs are treatable. The National Institute for Health and Care Excellence (NICE) identifies several recommended psychological treatments for EDs (National Institute for Health and Care Excellence, 2017). However, few patients with EDs have access to these treatments (Cooper and Bailey-Straebler, 2015). One group especially at risk for inequitable ED treatment access is patients with low income (Accurso *et al.*, 2021; Moreno *et al.*, 2023).

Despite EDs being equally prevalent across socio-economic categories (Huryk *et al.*, 2021), patients and families with low income are susceptible to encountering multiple barriers in accessing evidence-based care. In part, this is likely due to the intersection of low-income and other vulnerability factors. For example, low income is associated with having lower education levels, being from a historically marginalized racial/ethnic group, identifying as a sexual or gender minority, having limited English proficiency, and endorsing acculturative distress related to immigration status. All these factors are associated with worse mental health outcomes (Cervantes *et al.*, 2019; Kivimäki *et al.*, 2020; Ridley *et al.*, 2020). Patients with low income are known to be at increased risk for mental health disorders (Ridley *et al.*, 2020; Sareen *et al.*, 2011), yet are less likely to seek treatment (Sonnevile and Lipson, 2018), and more likely to be misdiagnosed (Cachelin *et al.*, 2001; Pulsifer *et al.*, 2019).

The combination of these factors often delays or prevents treatment access, thereby intensifying the negative health and psychological impact of EDs on this population. For example, data suggest that individuals with EDs categorized as low income have exacerbated symptoms. In Australia, for example, below-median annual household income has been associated with increased prevalence rates of binge eating, purging, and strict dieting (Mitchison *et al.*, 2014). In the US, higher rates of body dissatisfaction and unhealthy weight control behaviours have been reported by adolescents and emerging adults with lower socioeconomic status (Larson *et al.*, 2021).

Guidance on improving the equity of access to evidence-based care for patients with EDs and low income is lacking for real-world therapists; it is therefore crucial to explore and develop solutions (Harvey and Gumport, 2015; Kazdin, 2017; Kazdin *et al.*, 2017). Our out-patient ED specialty clinic (S.B.-S., E.A.) is part of an academic hospital located in a major metropolitan city on the East Coast of the US. Here we provide a case for equitable access to ED treatment through accommodations and examples based on clinical experience (S.B.-S., E.A.). We discuss how to apply this framework to reduce barriers and enhance fidelity to standards of evidence-based care.

Equitable treatment access via accommodations

Due to a lack of diversity and representation in clinical research (Burnette *et al.*, 2022; Hartman-Munick *et al.*, 2021; Smolak and Striegel-Moore, 2001), very little is known about how current treatments perform in patients with low income. Although some of the major randomized control trials providing the evidence for recommended ED treatment report including patients of different income levels, income is neither routinely analysed in relation to outcome nor clearly detailed (Byrne *et al.*, 2011; Fairburn *et al.*, 2009; Fairburn *et al.*, 2015; Wonderlich *et al.*, 2014). For example, 'occupational social class' is reported in some studies (e.g. Fairburn *et al.*, 2009), but this may or may not be aligned with income. Other reports include an income category cut-off (>\$100,000) which is well above a low-income threshold (Le Grange *et al.*, 2015).

Research assessing the efficacy of evidence-based psychological treatment for EDs – or the need for adaptations – in a wider, more representative range of patients is greatly needed. However, such trials are time consuming and costly. Borrowing language from the education model of *accommodations* (equitable access to the same content) and *modifications* (change in the content and expectations) (McGlynn and Kelly, 2019), we propose that in the meantime, rather than modifying the treatments and risk diluting their potency, we can identify the barriers that prevent patients from accessing recommended treatments and work to remove them. In education, accommodations are designed to promote equity in learning by assuring that all students have access to the same teaching content with the expectation that this will provide the same potential to learn. Translating this concept to the provision of psychological treatment, the aim is to increase complete access to the therapy for all individuals who need it. Our experience suggests that barriers that are especially likely to be encountered by individuals with low income can be overcome when appropriate accommodations, rather than modifications, are implemented.

Barriers

To know where accommodations may be needed and what form they might take, barriers to equal access for therapy must first be identified. Table 1 lists the barriers we have encountered and also the potential remedies we use in our clinic. Below, barriers are illustrated using composite case vignettes and we offer additional ideas about accommodations based on available data and clinical experience. We consider barriers that are encountered by many individuals seeking psychological treatment and highlight how certain barriers are likely experienced more acutely by patients with low income. Additionally, we explore treatment barriers unique to patients with EDs and low income (e.g. food insecurity, access to means for food preparation and storage) and suggest possible accommodations based on our clinical work.

Case-based examples

1. Poor case identification

J, a Black, 68-year-old, straight, cisgender man was receiving treatment for social anxiety in a community mental health clinic. Although his longstanding anxiety symptoms were clearly impacting many aspects of his life, they centred on concerns about body shape, weight, and eating. When therapeutic progress was slow, his therapist considered if his social anxiety was related to an underlying ED. J had never been assessed for an ED and was reluctant. He asked how it could be possible for a man of his size (he was in a larger body, body mass index (BMI) of 39) who relied on food from a food bank, to have an ED. An assessment determined that J met criteria for atypical anorexia nervosa, and that the ED likely dated back to his teens.

Mis-diagnosis and under-diagnosis, well-described elsewhere (Fursland and Watson, 2014; Kornstein *et al.*, 2016; Strother *et al.*, 2013), are associated with low rates of treatment-seeking for individuals with EDs (Hart *et al.*, 2011). Reluctance to seek care may be fuelled by shame and stigma, poor mental health literacy (Grammer *et al.*, 2022; Hamilton *et al.*, 2022; Sonnevile and Lipson, 2018), denial of the illness and the belief that others cannot help (Radunz *et al.*, 2023). Delays in diagnosis or treatment-seeking are especially prominent in historically marginalized ethnic/racial groups, men, and individuals in larger bodies (Becker *et al.*, 2003; Coffino *et al.*, 2019; Garb, 2021; Gewirtz O'Brien *et al.*, 2021; Harrop, 2020; Marques *et al.*, 2011; Sonnevile and Lipson, 2018), which may be related to higher levels of stigma felt by these groups (Benuto *et al.*, 2019; Griffiths *et al.*, 2015). Unfortunately, early descriptions of individuals with EDs – focusing nearly exclusively on white, young, cisgender women, from higher socioeconomic backgrounds (Smolak and Striegel-Moore, 2001) – inform implicit bias.

Table 1. Identified ED treatment barriers, accommodations and considerations

Barrier	Accommodations and considerations
1. Poor case identification	<ul style="list-style-type: none"> • Challenge pre-conceived notions of who develops EDs • Offer seminars and access to online trainings • Discuss the importance of early intervention and the existence of effective treatments • Discuss the impact of shame, stigma, denial, and the belief that others cannot help on treatment seeking • Provide guidance and access to screening tools
2. Inadequate numbers of trained therapists	<ul style="list-style-type: none"> • Utilize lower cost online trainings • Offer in-house supervision and/or adherence checklists • In locations where it is possible, task-shifting (training non-specialists) and program-led treatment is encouraged
3. Direct and indirect treatment costs	<ul style="list-style-type: none"> • Discuss and address patient/family ability to pay session fee for a 6- to 12-month course of treatment (based on insurance coverage, income, etc.) in countries without nationalized health services • Discuss ability to attend sessions in person, arrange for public insurance covered transportation when possible • Assess access to working technology (e.g. laptops, tablets, smartphones) to attend telehealth sessions, have back-up landline numbers • Work with local libraries to supply required reading for treatment • Provide patients with weighing scales, if needed, for weekly weight monitoring • Ensure distraction activities are affordable and accessible • Prescribe nutritional supplement drinks through medical providers when needed for weight regain in countries where supplements are not freely available to patients • Utilize charity shops as an option for low-cost clothing
4. Circumstances impacting implementation	<ul style="list-style-type: none"> • Consider which evidence-based treatments are possible for the family and/or patient to implement • Involve school personnel and other supports
5. A lack of cultural humility	<ul style="list-style-type: none"> • Increase therapist awareness of the impact of one's culture on patient/family's ability to meaningfully engage with therapy • Assess family/patient view of mental illness and EDs • Evaluate culturally informed attitudes about food • Inquire about religious and other holidays that may impact eating
6. Food insecurity	<ul style="list-style-type: none"> • Assess for food insecurity, with attention to treatment goals (e.g. weight restoration, implementation of 'regular eating') • Provide guidance for registration and access to government funded food support and/or local food banks • Engage with local food banks
7. Housing, energy, and technology insecurity	<ul style="list-style-type: none"> • Assess for housing, energy, and technology insecurity • Assess access to internet • Evaluate access to a kitchen, and electricity and fuel to prepare and store foods • Provide guidance on accessing relevant governmental support resources
8. Limited accessibility of treatment materials	<ul style="list-style-type: none"> • Translate treatment materials • Ensure appropriate readability level • Provide interpreters – spoken language and sign language

To reduce stigma and increase awareness, our clinic (S.B.-S., E.A.) holds virtual seminars throughout the year and on request for schools, libraries, and community health clinics, and offers guidance on screening tools and treatment referrals. The educational content emphasizes that EDs are treatable serious illnesses that may affect individuals regardless of race, ethnicity, gender, sexual orientation, age, and weight.

Broader educational efforts to improve knowledge about ED diagnosis among healthcare providers and trainees are also underway globally. Newer educational initiatives that leverage technology to reach trainees efficiently and effectively may be low-cost options (Kerfoot *et al.*, 2012; Maguire *et al.*, 2019; Raffoul *et al.*, 2022). To this end, our group (D.R.G., E.A.) created PreparED, a freely available, US-based, online curriculum for healthcare trainees and non-specialist providers (Glasofer *et al.*, 2020; Glasofer and Attia, 2021).

When providing seminars and other education guidance we strongly encourage the use of ED-specific screening tools. These measures assist in accurate identification of EDs and have a demonstrable positive impact on referrals when used by general practitioners (Wade *et al.*, 2022). It is also recommended that all initial psychiatric evaluations include screenings for EDs (Crone *et al.*, 2023). Several transdiagnostic and diagnostic specific, brief screeners exist (Gormally *et al.*, 1982; Maguen *et al.*, 2018; Morgan *et al.*, 1999; Stice *et al.*, 2000; Yanovski *et al.*, 2015).

2. Inadequate numbers of trained therapists

P, a 24-year-old, Asian-American man, was aware of the recommended treatments for bulimia nervosa. He contacted our center looking for a specific type of evidence-based treatment. He reported that he had called what felt like 'hundreds' of therapists on a referral website only to find that very few therapists provided this therapy and none of them were in his area or had openings. *P* described feeling hopeless about receiving the treatment he needed.

The paucity of therapists trained in evidence-based treatments for EDs is a major barrier (Cooper and Bailey-Straebler, 2015) and is likely even more pronounced in clinics serving individuals with low income (Accurso *et al.*, 2021). Training typically consists of an expert-led workshop, reading an associated treatment guide, and clinical supervision. However, few therapists receive this training (Kazdin *et al.*, 2017), primarily due to associated fees and indirect costs (i.e. time away from work) (Pagoto *et al.*, 2007). In the US, the majority of therapists with training credentials to offer these treatments do not accept third-party payment (i.e. insurance plan coverage) for this care, instead requiring out-of-pocket payment (Accurso *et al.*, 2021), making these treatments impossible for patients with low income to access.

Some cost-effective training methods are available, which we utilize in our clinic. Low-cost asynchronous web-based training, for example, is an option for ED treatments such as enhanced cognitive behaviour therapy (CBT-E) (Frank *et al.*, 2020). Once trained, treatment session adherence checklists (e.g. Bailey-Straebler *et al.*, 2022) may be a helpful method to reduce therapeutic drift and ensure fidelity to the selected approach (Waller and Turner, 2016).

Task-shifting/sharing (training non-specialists, i.e. peers, to provide therapy), program-led (e.g. app-based) and low-intensity treatments (self-help books; 6 hours or less of therapist contact) are additional cost-effective ways to overcome the challenge of inadequate numbers of trained therapists (Davey *et al.*, 2023; Fairburn and Patel, 2014). Unfortunately, these options are not available to patients with low income who receive government-funded health insurance in the US, where reimbursement requirements stipulate that only licensed therapists can provide psychological treatment.

3. Direct and indirect treatment costs

S, a 43-year-old transgender Chinese woman with binge eating disorder, lived about 75 miles from our clinic and relied on public transportation. The cost (close to \$100 roundtrip return ticket train fare and taxi fare from the station to the clinic) to attend the required in-person evaluation was unaffordable. Fortunately, we were able to arrange transportation for her

through her public insurance.¹ S reported that this was a ‘huge relief’ and without this option she would not have been able to attend the evaluation session, which would have made her ineligible for treatment.

Cost of treatment is a frequently cited barrier to ED treatment (Ali *et al.*, 2017). This includes direct (e.g. session fees) and indirect (e.g. loss of work time, transportation, childcare) costs. Although telehealth has greatly reduced transportation-associated costs such as train fare, parking fees, or petrol, it has created other related treatment costs (e.g. cost of mobile devices, internet access, and electricity use). Additionally, there remain times when travel costs continue to prevent attendance (Bischoff *et al.*, 2004). For example, some patients with EDs prefer in-person sessions (Pagano *et al.*, 2023), and some services are required to see patients in-person for evaluation sessions or prior to prescribing controlled substances. For these situations, therapists are encouraged to investigate available transportation schemes. In the US this includes transportation provided by some types of government-based insurance and in the UK the National Health Services’ (NHS) Healthcare Travel Costs Scheme may provide travel reimbursement to eligible participants (based on income and/or disability) (National Health Service, 2020).

There are multiple hidden costs to sessions conducted via telehealth. Telehealth necessitates that patients have access to computers, tablets or smartphones capable of hosting or maintaining an adequate wireless connection to the required telehealth platform (e.g. app or website). Telehealth also incurs further costs related to internet and electricity, described in detail below. Additionally, this modality has resulted in patients needing to buy or be provided with weighing scales to be used at home during sessions for treatment plans that require regular weight monitoring. When possible, we provide patients with weighing scales that have been donated to our clinic.

Cost of other treatment materials is also a factor worth considering. For example, many ED treatments rely on the use of nutritional supplement drinks to help patients regain weight. These drinks are extremely costly when sold individually. In locations where these drinks are not freely supplied to patients in need, it can be useful to explore if a patient’s health insurance will pay for them. In the US, for instance, some government-funded insurance will cover the cost when drinks are deemed medically necessary and prescribed like medication. Equally it is important to consider the costs of any between-session work. Some treatments suggest supplementary reading materials. Borrowing from the Books on Prescription model utilized by the NHS (Brewster, 2009), we frequently partner with local libraries to provide access to these reading materials (e.g. *Overcoming Binge Eating*; Fairburn, 2013). Treatments also encourage engaging in distraction activities or returning to hobbies. Finding low-cost or cost-free activities that are accessible in the patient’s location is essential. Finally, sometimes there is the need to have patients obtain new clothing. This may be related to changes in weight or as a part of tackling body avoidance. Charity shops provide an option for low-cost clothing.

4. Circumstances impacting treatment implementation

D, a 17-year-old, Hispanic, straight, cisgender man with anorexia nervosa, restricting subtype. D’s parents worked long hours without much flexibility. Although he had extended family nearby, D’s parents had concerns about involving other family members in meal preparation or support. Due to the family’s constraints, he was recommended to receive a primarily individually based, rather than family-based, treatment. D’s parents felt confident that he would independently

¹In the US, third-party payment for health care includes health insurance plans that are either offered by private companies (aka ‘commercial insurance’), or by government programs (aka ‘public insurance’), including the federal Medicare program for individuals over 65 years and younger individuals with disabilities, and the state-issued Medicaid programs for individuals with low income.

attend sessions regularly and that they could support him in completing homework assignments and participate in a handful of sessions.

In our experience, implementing family-based therapies (e.g. family-based therapy (FBT) for anorexia nervosa/the ‘Maudsley Method’) has been challenging and extra burdensome for some of our families with low income. A sizable proportion of these families are single-parent households, or households in which parents work more than one job to support the family. This understandably impacts parents’ availability to prepare and supervise meals, which can have downstream effects on the effective implementation of family-based therapies. Providing accommodations such as additional support via extra therapy sessions and increased school involvement has been helpful, although is often insufficient. Of note, in cases where families with low income are able to fully implement FBT, we have seen great successes. It is therefore crucial to ensure that patients and families can effectively implement suggested treatments. Careful assessment and consideration of the patient and family’s ability to effectively utilize the treatment prior to starting treatment has allowed for more appropriate treatment allocation. For example, family-based therapies and individual/adolescent-based therapies (e.g. adolescent focused therapy (AFT) or CBT-E for adolescents) are recommended treatments for youth with restrictive EDs (National Institute for Health and Care Excellence, 2017); and while there are no clear predictors of outcome in favour of one versus the other (Le Grange *et al.*, 2020), the treatments differ in terms of the optimal environment for success (full description of AFT here: Fitzpatrick *et al.*, 2010; and full description and comparison on FBT and CBT-E here: Dalle Grave *et al.*, 2019). Consequently, all are reasonable choices and therapists can make thoughtful, informed recommendations based on the available home support and family preference.

5. A lack of cultural humility

In both the UK and US, individuals meeting criteria for low income represent ethnically diverse backgrounds and cultures (Department for Work and Pensions, 2022; Donohue *et al.*, 2022). Therapist cultural awareness improves patient and family engagement in treatment and is associated with decreased rates of treatment drop-out. Some (Heim and Kohrt, 2019; Perera *et al.*, 2020) have argued in favour of adapting treatments to achieve cultural humility, while others believe that doing so has the potential to dilute treatments, rendering them less effective or place them at risk for missing individual variations that exist within similar cultural groups (Hall *et al.*, 2016; Healey *et al.*, 2017). There has been limited work exploring cultural adaptations to ED treatment, with initial studies suggesting that only minor modifications may be required (e.g. devising meal plans that incorporate culturally familiar foods) (Acle *et al.*, 2021; Shea *et al.*, 2012; Shea *et al.*, 2016).

To increase cultural humility in our clinic, we work to (1) increase therapist cultural sensitivity and awareness; (2) encourage the use of culturally informed interviews; and (3) consider ways that ED treatment and culture intersect. These efforts combined serve as a foundation for therapists to assess the family’s and patient’s views of mental illness (and EDs specifically) and psychological treatment.

We encourage all staff to attend ongoing professional development and discussions on topics such as: the impact of a patient’s culture on their illness, engagement in treatment, and symptom description; the possibility of culturally specific stigma; and relevant treatment adaptations (Cherestal *et al.*, 2023). Ongoing supervision then retains an attunement to culture.

Incorporating the tone and style of questions included on the Cultural Formulation Interview (CFI) (American Psychiatric Association, 2013) can be helpful. The CFI is a 16-question mental health assessment tool, designed to inform clinicians on the impact of culture on clinical presentation. Where relevant, we add questions focused on food and eating. For example, in the section on cultural identity we include: *‘Food is often an important part of one’s culture and identity. Many cultures and religions engage in events/celebrations throughout the year, for example*

days of fasting or periods of feasting. For you/your family, what important events/celebrations/important religious obligations include eating/not eating/eating specific foods?.

Standard eating practices are often culturally bound, including food choices (e.g. restrictions around certain meat or fish products), the availability of and family practices around food (e.g. individual roles in grocery shopping or food preparation, eating environment and mealtimes), and holiday customs. Cultural norms for beauty related to body shape, weight and height can also greatly impact treatment. If EDs are viewed as lifestyle choices rather than mental illnesses with potentially life-threatening physical correlates (Hamilton *et al.*, 2022), psychoeducation about the seriousness and dangerousness of these disorders is emphasized.

6. Food insecurity

S is a 12-year-old white cisgender girl with anorexia nervosa, binge-purge subtype. Due to low income, her parents struggled to provide enough food for their family. The clinic provided support in several ways: (1) involving S's school to get her the available free food options, (2) assisting her parents in registering for a national government food assistance program, (3) connecting her parents to local food banks, and (4) guiding her family in seeking school-based accommodations under Section 504 of The Rehabilitation Act,² which granted S access to support while eating and a quiet space to engage in telehealth therapy sessions during the school day.

Once the family was more food secure, we assisted S in overcoming other food-related challenges. Many foods provided by the school and the food bank were items that she avoided due to fear of weight gain. The foods delivered by the food bank and government-funded program were tied to a calendar, which inadvertently worsened her feast-or-famine mentality. S's therapist, aware of how food insecurity and food assistance programs inform cycles of restriction and binge eating, coached her parents to take responsibility for portioning out foods when they arrived. Everyone in the family understood the importance of eating roughly similar amounts throughout the month to protect against the cycle.

Food insecurity, a 'lack of consistent access to enough food for every person in a household to live an active, healthy life' (U.S. Department of Agriculture, 2022), is associated with worse health outcomes (Kushel *et al.*, 2006) and disproportionately impacts individuals with low income and those from marginalized racial/ethnic groups (Myers and Painter, 2017). In 2020, nearly 15% of US households with children experienced food insecurity, with the numbers dramatically increasing throughout the pandemic (Wolfson and Leung, 2020). In the UK, numbers of those experiencing food insecurity are similar (Environmental Audit Committee, 2019). A recent UK-wide survey of ED health professionals highlighted insufficient awareness of food insecurity and strongly called for the development of guidance, training, and a policy response from the government (Kuehne *et al.*, 2023).

Given that food is the primary medicine in many ED treatments, it is unsurprising that issues related to food scarcity would uniquely affect individuals with these disorders. The impact appears particularly pronounced in EDs that are characterized by binge eating (i.e. bulimia nervosa, binge eating disorder, anorexia nervosa binge purge subtype) (Hazzard *et al.*, 2020). While the mechanism of the relationship remains unclear, one possibility is the restriction–binge cycle may be influenced by federal programs in place to assist individuals with low income. In the US, assistance typically renews on a monthly basis. Individuals may over-eat when there is an abundance of food at the start of the cycle and be forced to restrict their eating as resources wane

²Section 504 is a Federal US civil rights law protecting equal rights of individuals with disabilities, including emotional and mental illness during their school day.

towards the end of the cycle, potentially promoting the ‘feast-or-famine’ cycle of food availability known to be associated with problematic eating behaviours (Hazzard *et al.*, 2020).

7. Housing, energy, and technology insecurity

When M, an Italian American 19-year-old cisgender woman, started treatment in our clinic for avoidant/restrictive food intake disorder (ARFID), she and her family had stable housing and were living with other family members. In the years prior, they had struggled to secure housing, twice faced eviction from their apartment, and once lived in an emergency housing shelter for homeless families. In the present housing arrangement, although M’s family was able to pay their rent, they were frequently unable to pay associated living costs including their electricity bill. As a result, M worried about the cost of warming and cooking foods. Helping M to broaden her array of meals while planning for foods that could be eaten with little preparation was essential.

Difficulty paying rent, facing eviction, frequent moving, overcrowding, and poor neighbourhood safety/quality, are all barriers to health care among individuals with low income (Kushel *et al.*, 2006). Energy insecurity, the ‘inability to adequately meet basic household energy needs’ (Hernández, 2016), can include difficulties in affording heating, cooling and electricity. Immigrants, individuals with low income, and those identifying as from a historically marginalized ethnic/racial group disproportionately encounter both housing and energy insecurity (Memmott *et al.*, 2021). In the US, energy insecurity is a factor for roughly 30% of the US population (Hernández and Laird, 2022; Beall and Hronis, 2022) and according to 2021 UK census data, adults with an annual personal income below £30,000 were nearly three times as likely to report energy insecurity than those with an annual personal income over £40,000 (Office for National Statistics, 2023).

For patients who opt for telehealth, taking time to determine what kinds of technology (internet access and devices) are available in the home, available space to have the session, as well as comfort level in using online technologies is important. In the US, individuals from historically marginalized racial/ethnic groups and those with low income are less likely than their white and higher-income counterparts to have internet access (Ko *et al.*, 2023). Prevalence of households with no internet may be as high as 21–29% for Black and Hispanic youth with low-income nationally (Dolcini *et al.*, 2021). In the UK, as of 2018, 10% of the adult population faced ‘digital exclusion’, with those in lower income levels, ethnic minorities, older adults, and those with disabilities being the most disadvantaged (Office for National Statistics, 2019).

The scope of the problem is vast, and the role that physical space and access to electricity play in supporting elements of ED treatment such as food preparation and storage, and internet access and privacy for telehealth sessions are noteworthy. Therapists are advised to approach this barrier similarly to food insecurity, to assess carefully and provide guidance on relevant governmental, community, or non-profit charitable support resources.

8. Limited accessibility of treatment materials

To provide equal access to treatment, we must deliver care in the language most understood by patients. Limited English proficiency (LEP) (or limited primary language proficiency in locations where English is not the primary language) leads to health disparities associated with low mental health literacy, less disclosure, and inappropriate diagnosis (Bauer and Alegría, 2010; Foiles Sifuentes *et al.*, 2020; Ohtani *et al.*, 2015). The highest rates of LEP are found in individuals with low income and among immigrants (Aoki and Santiago, 2018; Foiles Sifuentes *et al.*, 2020). For example, in New York State, US, 24% of non-elderly recipients of Medicaid health insurance met criteria for LEP (Haldar *et al.*, 2022). Similarly in the UK, fewer than half (48%) of individuals who classify as LEP are employed (Office for National Statistics, 2015).

Providing therapy in the patient's preferred language is ideal given preliminary evidence of improved outcomes and patient satisfaction (Hsueh *et al.*, 2021; Molina and Kasper, 2019). When possible, therapists fluent in the patient's language (language-concordant care) should be utilized; however, therapists who speak more than one language are rare. Our service provides in-person, telephone, video- and app-based interpreters for foreign languages and American Sign Language. Use of professional interpreter services is associated with improvements in healthcare outcome (Brandl *et al.*, 2020) and appears to consistently be more effective than *ad hoc* interpreters across different modes of treatment delivery (i.e. in-person, on video, by telephone) (Boylen *et al.*, 2020). It is recommended that patient education materials be checked for reading accessibility and literacy levels, with the aim that all hand-outs be equivalent to the recommended 5th reading level (Stossel *et al.*, 2012). Utilizing methods such as 'teach back' (Griffey *et al.*, 2015) helps clinical staff assess patient understanding and knowledge acquisition.

Future directions

Patients with low income face enormous obstacles in accessing evidence-based treatment. Providing equitable care involves consideration of the needs of individuals with low income including the many related factors that give rise to health disparities such as socioeconomic status, language diversity, and the impact of being from a historically marginalized racial and/or ethnic group. Extending the reach of these treatments is possible with special attention to identifying and removing barriers to accessing treatment. The accommodations reviewed in this paper offer ways to overcome the obstacles patients with low income may encounter when seeking and receiving care.

To improve ED treatment accessibility for patients with low income, the following topics require prioritization:

(1) Further identification and investigation of barriers: fully identifying the barriers individuals with low income encounter when seeking and receiving ED treatment is needed. Many more barriers likely exist than those reviewed here. For example, low income is associated with increased stress levels and co-occurring mental health conditions, all of which can interfere with treatment implementation (Wade *et al.*, 2023) and reduce the effectiveness of psychological treatment (Finegan *et al.*, 2018). Location-specific barriers related to income also need further exploration (e.g. barriers encountered by patients in countries with nationalized versus single-payer healthcare services, and rural versus urban areas). Importantly, qualitative work involving individuals with lived experience of an ED and low income in terms of accessing and implementing evidence-based treatment is non-existent and crucial to further barrier identification.

(2) Evaluation of clinical efficacy: research is needed to evaluate the impact of the accommodations described here on clinical outcomes. In our experience, removing the barriers listed has allowed patients from a variety of backgrounds to meaningfully engage with and complete evidence-based treatment; our impressions, however, are anecdotal. Large-scale investigations are required to extend the reach of evidence-based psychological treatments equitably, efficiently and effectively.

(3) Exploration of therapist and clinic implications: accommodations are time consuming, often requiring therapists to use valuable clinical hours to take on additional roles resulting in fewer patients being seen. Additionally, providing treatment while managing many different accommodations is mentally burdening and may add to levels of moral distress. Moral distress, characterized as distress caused by repeatedly not being able to carry out professional standards of care (Epstein *et al.*, 2019), is associated with negative feelings, compromised patient care, and higher staff turnover (Henrich *et al.*, 2017). Clinics might also find it economically unfeasible to pay for the costs of therapist training, treatment material translation, and interpreter provision.

Consequently, the financial (and psychological) implications for therapists and clinics might inadvertently create additional barriers for patients with low income. As the field moves forward in improving equitable access to evidence-based ED treatment, it will be essential to evaluate and mitigate the challenges to individual therapists and health care systems.

Key practice points

- (1) Psychological treatment for EDs can be effectively implemented for a range of patients including those with low income.
- (2) Rather than offering evidence-based interventions in a manner that may dilute their potency, thoughtful, modest accommodations are ideal to extend the reach of first-line treatments.
- (3) When implementing ED treatment, therapists are encouraged to assess for barriers that may prevent a patient from fully engaging with the therapy. These obstacles include, but are not limited to: food, housing, and energy insecurity; associated direct and indirect treatment costs; cultural factors that are individual to each patient.

Further reading

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Data availability statement. Data availability is not applicable to this article as no new data were created or analysed in this study.

Acknowledgements. We thank George Alexopoulos, Justin Chen, Rachel Moster and Katharine Phillips for their feedback on an earlier version of this manuscript. We are grateful to Maura Lehr and Michael McIntosh for their support of this program. We especially thank and highlight the contributions of Samantha Berlow, Melissa Cemel, Laura Cordella, Fayrisa Greenwald and Dominique White for providing the treatment described in this paper.

Author contribution. **Suzanne Bailey-Straebl**: Conceptualization (lead), Writing – original draft (equal), Writing – review & editing (equal); **Deborah R. Glasofer**: Conceptualization (supporting), Writing – original draft (equal); Writing – review & editing (lead); **Jessica Ojeda**: Formatting manuscript and references (lead); Writing – review (supporting); **Evelyn Attia**: Writing – review & editing (supporting).

Financial support. This research received no specific grant from any funding agency, commercial or not-for-profit sectors.

Competing interests. S.B.-S., J.O.: none; D.R.G. has received honoraria from Oxford University Press. E.A. receives royalties from Wolters Kluwer and serves on the Clinical Advisory Board of Equip Health, Inc.

Ethical standard. In our treatment and provision of care we have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the British Association of Behavioural and Cognitive Psychotherapies and the British Psychological Society. The vignettes presented represent composite cases resembling the types of patients we typically encounter in our clinic. There are no identifying features of any specific patients. Therefore, no patient consent was required.

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Cite this article: Bailey-Straebler S, Glasofer DR, Ojeda J, and Attia E. Equitable access to evidence-based treatment for eating disorders for patients with low-income: identifying barriers and exploring solutions. *The Cognitive Behaviour Therapist*. <https://doi.org/10.1017/S1754470X24000023>