2: 326 words

Binge eating disorder (BED) is an autonomous DSM-5 mental health diagnosis with high lifetime prevalence rates and a complicated health sequalae that significantly impairs quality of life. Standard of care interventions for BED have low treatment success rates (38–44%), high recurrence rates (49–64%), and early discontinuation of care. Moreover, 93–97% of individuals who meet DSM criteria for BED never receive a formal diagnosis, 67% do not perceive the need for formal treatment, and 56–87% never pursue or receive standard treatment, due in part to a variety of treatment barriers. Bray et al. (2024) provides an in-depth review of literature pertaining to existing barriers that can hinder BED identification (stage 1), treatment-seeking (stage 2), and treatment access and engagement (stage 3) at the levels of the patient, healthcare providers/systems, and the general public (including public health policy). Here, we propose a multifaceted approach to comprehensively address these barriers. Our approach involves targeted campaigns directed at three distinct audiences: 1) individuals who experience BED; 2) healthcare workers and systems who care for individuals with BED; and 3) the broader public sphere shaping the environment BED exists in. These campaigns should focus on dispelling stigma and raising awareness about BED prevalence, demographics, treatment options, and funding avenues. Incentivizing provider education through certifications, enhancing financial aid and insurance coverage, and establishing user-friendly online platforms that consolidate resources and multi-provider communication can further mitigate these barriers. Additionally, allocating research funding is imperative to develop and test treatment modalities that are: 1) free or low-cost; 2) remote/virtually accessible or community based; 3) socio-demographically sensitive and inclusive; and 4) sensitive to the unique experiences of individuals with BED. We propose five major solution aims and discuss current literature findings and public policy campaigns that support these solutions. Overall, our proposals align with existing literature, endorsing collaborative efforts that involve healthcare, public policy, education, and research to combat BED barriers and improve BED detection and treatment-seeking, access, engagement, and success.

1: 390 words

Binge eating disorder (BED) is an autonomous DSM-5 mental health diagnosis with high lifetime prevalence rates and a complicated health sequalae that significantly impairs quality of life. Standard of care interventions for BED have low treatment success rates (38–44%), high recurrence rates (49–64%), and early discontinuation of care. Moreover, 93–97% of individuals who meet DSM criteria for BED never receive a formal diagnosis, 67% do not perceive the need for formal treatment, and 56–87% never pursue or receive standard treatment, due in part to a variety of treatment barriers. Bray et al. (2024) provides an in-depth review of literature pertaining to existing barriers that can hinder BED identification (stage 1), treatment-seeking (stage 2), and treatment accessing and engaging (stage 3) at the levels of the patient, healthcare providers and systems, and the general public (including public health policy). To address these challenges comprehensively, we propose a multifaceted approach involving targeted campaigns directed at distinct audiences: 1) individuals who experience BED; 2) healthcare workers and systems who care for individuals with BED; and 3) the broader public sphere shaping the environment BED exists in. Our five-point approach includes campaigns to: 1) increase public education about BED; 2) increase resources for equal-opportunity treatment engagement; 3) develop a free, unified/one-stop, online resource platform for individuals with BED and those seeking to help them; 4) increase education about BED within healthcare systems; and 5) offer certification and accreditation for provider trainings on BED. These campaigns should focus on dispelling misconceptions and stigmatization that surround BED by providing education on BED prevalence, demographics, scalable treatment options, and funding avenues. Incentivizing provider education through certifications, enhancing financial aid and insurance coverage, and establishing user-friendly online platforms that consolidate resources can further mitigate these barriers. Additionally, allocating research funding is imperative to develop and test treatment modalities that are: 1) free or low-cost; 2) remote/virtually accessible or community based; 3) socio-demographically sensitive and inclusive; and 4) sensitive to the unique experiences of individuals with BED. This proposal aligns with existing literature, endorsing comprehensive public policy campaigns to combat BED barriers and improve detection, treatment-seeking, and access. We also discuss current literature findings and public policy campaigns that support the solutions proposed here. Overall, addressing BED barriers necessitates collaborative efforts involving healthcare, policymaking, education, and research to enhance detection, access, and engagement in treatment.

3: 398

Binge eating disorder (BED) is an autonomous DSM-5 mental health diagnosis with high lifetime prevalence rates and a complicated health sequalae that significantly impairs quality of life. Standard of care interventions for BED have low treatment success rates (38–44%), high recurrence rates (49–64%), and early discontinuation of care. Moreover, 93–97% of individuals who meet DSM criteria for BED never receive a formal diagnosis, 67% do not perceive the need for formal treatment, and 56–87% never pursue or receive standard treatment, due in part to a variety of treatment barriers. Bray et al. (2024) provides an in-depth review of literature pertaining to existing barriers that can hinder BED identification (stage 1), treatment-seeking (stage 2), and treatment accessing and engaging (stage 3) at the levels of the patient, healthcare providers and systems, and the general public (including public health policy). In light of these findings, we emphasize the need for a variety of systems-level public policy solutions to improve BED detection, screening, diagnosis, and treatment-seeking, access, and engagement. These solutions require a collective effort from healthcare providers, policymakers, and researchers. We propose a multifaceted approach involving targeted campaigns directed at three distinct audiences: 1) individuals who experience BED; 2) healthcare workers and systems who care for individuals with BED; and 3) the broader public sphere shaping the environment BED exists in. We propose these campaigns focus on dispelling a variety of misconceptions, biases, and stigmatization that surround BED and providing information on BED prevalence, demographics, stigmatization, scalable treatment and funding options, and treatment benefits and champions. We suggest offering certifications and CME accreditations to help incentivize provider education and training on these topics. Financial aid and insurance coverage for treatment have improved but are still needed. Free, one-stop, online platforms with resources on BED risks, prevalence, demographics, detection, screening, treatment and financial aid options, and insurance information can further reduce many barriers and streamline treatment-seeking and access. Research funding is also needed to identify and test new treatment options that are: a) free or low-cost; b) community-based or virtually accessible; c-d) culturally and demographically sensitive and inclusive. Lastly, we discuss current literature findings and public policy campaigns that support the solutions we propose here. Overall, our proposal aligns with existing literature, endorsing collaborative efforts that involve healthcare, public policy, education, and research to combat BED barriers and improve BED detection and treatment-seeking, access, engagement, and success.

4: 584 words

Binge eating disorder (BED) is an autonomous DSM-5 mental health diagnosis with high lifetime prevalence rates and a complicated health sequalae that significantly impairs quality of life. Standard of care interventions for BED have low treatment success rates (38–44%), high recurrence rates (49–64%), and early discontinuation of care. Moreover, 93–97% of individuals who meet DSM criteria for BED never receive a formal diagnosis, 67% do not perceive the need for formal treatment, and 56–87% never pursue or receive standard treatment, due in part to a variety of treatment barriers. Bray et al. (2024) provides an in-depth review of literature pertaining to existing barriers that can hinder BED identification (stage 1), treatment-seeking (stage 2), and treatment accessing and engaging (stage 3) at the levels of the patient, healthcare providers and systems, and the general public (including public health policy). In light of these findings, we emphasize the need for a variety of systems-level public policy solutions to improve BED detection, screening, diagnosis, and treatment seeking, access, and engagement. These solutions require a collective effort from healthcare providers, policymakers, and researchers. We propose a multifaceted approach involving targeted campaigns directed at three distinct audiences: 1) individuals who experience BED; 2) healthcare workers and systems who care for individuals with BED; and 3) the broader public sphere shaping the environment BED exists in. Our five-point approach advocates first (1) for publication campaigns to increase public education about BED that focus on a) reducing stigmatization that impedes BED recognition, treatment-seeking, and treatment-engagement; b) enabling self-identification; c) promoting treatment-seeking and engagement; d) simplifying treatment-seeking and enabling treatment access; and e) providing publication education on provider-level treatment barriers (e.g., stigmatization, unequal screening in minorities, weight bias, poor education related to BED pathology and treatment resources and ignorance of the importance of rapid response for BED recovery within healthcare systems). Second (2), we propose the need for public campaigns to increase resources for equal-opportunity treatment engagement. This includes increasing financial aid options and insurance coverage for BED treatment, in-line with the Anna Westin Act of 2015 (H.R.2515,S.1865) and increasing federal funding for research aiming to identify and test new treatment options that are: a) free or low-cost; b) community-based or virtually accessible; c-d) culturally and demographically sensitive and inclusive. Third (3), we call for development of a free, unified/one-stop, online resource platform for individuals with BED and those seeking to help them. The platform can provide resources in six core areas with 6 core sub-aims: a) increasing public education about BED (that parallel aim 1); b) screening tools for self-identification; c) scalable treatment options (as addressed in aim 2); d) coordinating communication and care across multi-disciplinary providers; e) individuals with BED who experience stigmatization; and f) resources for healthcare providers specifically focused on disseminating information about stigmatization, weight bias, under-screening, and medical decision-making (including diagnostic tools and treatment options) within healthcare systems. Fourth (4), we underscore the need for public health campaigns to increase education about BED within healthcare systems, aiming to: a) reduce stigmatization and weight bias; b) increase recognition, screening, and detection; c) promote narrative-based medicine; d) increase provider education and training on BED treatment options and resources; and e) streamline interdisciplinary treatment processes and communication. Lastly, fifth (5), we suggest offering certification and accreditation for provider trainings on BED to further support Aim 4. Overall, addressing BED barriers necessitates collaborative efforts involving healthcare, policymaking, education, and research to enhance detection, access, and engagement in treatment, thus helping to address this major global health issue.