

Committee Members,

My name is Dr. Julia Sadusky and I am a licensed psychologist in Colorado. I am sorry I could not attend in-person or virtually, as I am presenting at a conference during the time of the bill testimony. However, I did want to take the time to submit written testimony due to my belief that this bill is a critical foundation for reform that will protect many Coloradans.

I have practiced in Colorado in an eating disorder clinic offering partial hospitalization/intensive outpatient/ and outpatient care, in a general group practice, and in private practice. I have also coordinated care with many eating disorder facilities in the state and have a significant level of familiarity with these program structures. Additionally, I have worked in residential chemical dependency/substance abuse treatment facilities, including a detox unit and 30-day residential program outside of the state of Colorado, which has allowed me to better understand how eating disorder facilities in Colorado compare with other facilities treating mental health concerns. I specialize in working with survivors of abuse and neglect, many of whom experience disordered eating.

I believe the proposed bill is an essential first step in addressing problematic systemic issues in eating disorder clinics. Colorado is a hub for treatment facilities, and there have been significant harms to my clients in these settings. It is likely difficult to fully appreciate the vulnerability of people coming to treatment at these higher levels of care. Many have come here from out of state to seek care, without the support of family or primary supports, and they give up a great deal of freedom to entrust their care to providers in eating disorder settings, in the hopes that these facilities will help and do no harm. Sadly, that is not always the case.

Because of lack of an overseeing body such as the Behavioral Health Administration, when clients have been harmed in these settings, there is zero recourse for them to ensure accountability and systemic reform, and no assurance of ongoing oversight to prevent future abuses. The impact of abuses and harms along with the lack of recourse to report such harms often has led my clients to question their own capacity to gauge reality and fostered increased self-blame and self-loathing, ultimately worsening their mental health concerns. For those who are survivors of abuse and neglect, which is the case for every eating disorder client I have worked with, lack of recourse for these harms exacerbates hopelessness, lack of motivation for future treatment, and is too often a recreation of many peoples' past abuses, where people in positions of power and authority failed to report or provide avenues for accountability of those who harmed them. These systemic failures and the lack of structures of accountability ultimately have contributed to clients' increased suicidality, eating disorder behaviors, mood symptoms, etc., which are the very things these facilities purport to treat.

In light of this, there is a clear need for oversight and accountability for treatment facilities treating people with eating disorders in light of the magnitude of harm I have witnessed when no such recourse exists. I can attest that much of my work with these individuals has tragically included needing to process retraumatizing experiences at eating disorder facilities in addition to traumas that contributed to the onset of their symptoms originally. The very problems these clinics assert to address often are exacerbated due to lack of consistent implementation of evidence-based approaches, and lack of

appropriate intervention to protect patients when evidence-based approaches are lacking. Whereas substance abuse facilities and mental health inpatient settings do have oversight from a licensing body, it is of grave concern that eating disorder facilities are exempt from such regulation. I hope that this bill changes that.

Additionally, there is no set and mutually-agreed upon criteria for admitting or discharging individuals to eating disorder facilities. We must take into account how poor of a gauge BMI or bloodwork alone are in representing eating disorder severity. People with severe eating disorders can have relatively normal labs and not be deemed underweight by BMI alone. Too often, the determination of admission to various levels of care is based on these outdated metrics and left up to the clinical director/assessment team along with insurance companies, who often discriminate against those in larger sized bodies, despite severe patterns of restriction, purging, binge-eating, and laxative use and significant impacts of these behaviors including fainting, bone density problems, gastrointestinal damage, etc. The biases of providers, insurance utilization review staff, and those assessing, may view certain clients as less worthy of care, and will often inhibit access for certain people, despite behavior usage being significant and life-threatening.

This problematic process of assessment disproportionately impacts people of color who struggle to access care in these settings already. I often recall moments where members of my team spent significant time weekly arguing with an uneducated insurance reviewer who denied care for patients based on BMI alone. When that occurred, we were required to notify clients that their insurance company does not believe they are needing a certain level of care, which only reinforces and often leads a person to increase their use of behaviors to feel “deserving” of treatment. Even if ultimately the insurance company did approve care for another week, the consequences were great. This determination often led to a cycle of a client increasing behaviors to be deemed worthy of care. This could persist for an entire course of treatment because the client was afraid that they will not warrant treatment if they are not “sick enough,” leads to worsening symptoms, not improvement, over time. Rather than outdated metrics, I would recommend that frequency and intensity of eating disorder thoughts, urges, and behaviors and the impacts of past and current eating disorder behaviors on present functioning, including co-occurring mental health concerns, are a better gauge of treatment needs. I am encouraged that this bill seeks to offer that critical reform.

Finally, when an individual is in treatment, there is no set criteria that leads to objective determination of transition of care to a higher or lower level of care, and much of this determination is left to individual providers/insurance companies yet again. Too often, this determination is based on personal biases, preferential treatment to certain clients, and insurance status, rather than the genuine clinical needs of the client in question. I have witnessed how this has led to clients remaining in levels of care where they are not improving and transferring out of levels of care at the impulse of a provider. This is yet another indicator of the need for a licensing body to determine standards of care that are externally implemented, monitored, and enforced.

In Colorado, we can and need to do better for those who are suffering from eating disorders. While there is additional reform needed for clinics serving those with severe eating disorders, this bill offers a first-step to better gauge the effectiveness of these clinics, ensure proper oversight, offer recourse for clients who are harmed in mental health facilities, hold providers accountable who are working with

vulnerable teens and adults, and ensure that access to care is not based on outdated metrics that lack clinical utility in gauging level of care needs for individuals with eating disorders.

Respectfully,

Dr. Julia Sadusky



# Council for Responsible Nutrition

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## MEMORANDUM IN OPPOSITION

### Colorado Senate Bill 23-176 – Specific to Article 8

#### **Prohibits a retail establishment from selling, transferring, or otherwise furnishing dietary supplements for weight loss or over-the-counter diet pills to any individual under 18 years of age without a prescription**

The Council for Responsible Nutrition (CRN)<sup>1</sup> respectfully opposes Article 8 of SB 23-176 as currently written. This proposal would age-restrict consumer access to weight loss supplements, a **broad category** of dietary supplements and functional foods by requiring hundreds of products be restricted because of unjustified and unscientific concerns regarding products with wide margins of safety and long histories of safe use. While we understand this proposal may have stemmed from concerns about perceived misuse/abuse of certain products, CRN is alarmed by the legislation as drafted because of the bill's overly broad approach which categorizes safe, legal, and regulated dietary supplement products along with drugs and adulterated ingredients already banned from sale, reflecting a lack of understanding of today's dietary supplement marketplace as well as the federal regulatory framework for these products. This overly broad approach ultimately limits access of products without any scientific rationale for responsible Colorado consumers who may find benefit in legitimate products.

**There is no credible scientific data that dietary supplements lead to or cause body dysmorphia, eating disorders, or mental health issues.** We are committed to working with the Sponsors, the Colorado legislature, the Colorado Department of Public Health and Environment, the Behavioral Health Administration, and other stakeholders to address legitimate concerns relating to potentially dangerous and illegal products. This approach that targets a broad array of legitimate, federally regulated dietary supplement products is not the solution.

If enacted, the aforementioned referenced section of this proposal would:

- cast an overly broad net over hundreds of safe and beneficial weight management dietary supplements products;
- place unreasonable compliance and economic burdens on Colorado retailers who would be required to age-verify sales, pay grievous fines at first offense, and likely be forced to place hundreds of products behind a retail counter (at no small expense to reconfigure their aisles) to accommodate the check out process;
- place an enormous enforcement burden on the State to inspect thousands of stores, including but not limited to drugstores/pharmacies, gyms, yoga studios, bodegas, big box chains, supermarkets, and convenience stores as well as online retailers resulting in a cumbersome resource burden and financial cost to the State; and
- add more responsibility and impose financial burdens for regulation to the Colorado Department of Public Health and Environment and the Behavioral Health Administration, to determine what products can be sold in retail establishments statewide. Due to the hundreds of products

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<sup>1</sup>The Council for Responsible Nutrition (CRN), founded in 1973, is a Washington, D.C.-based trade association representing 190+ dietary supplement and functional food manufacturers, ingredient suppliers, and companies providing services to those manufacturers and suppliers. In addition to complying with a host of federal and state regulations governing dietary supplements and food in the areas of manufacturing, marketing, quality control and safety, our manufacturer and supplier members also agree to adhere to additional voluntary guidelines as well as to CRN's Code of Ethics. Visit, [www.crnusa.org](http://www.crnusa.org). Follow us on: Twitter [@CRN\\_Supplements](https://twitter.com/CRN_Supplements), [Facebook](https://www.facebook.com/CRNUSA), and [LinkedIn](https://www.linkedin.com/company/crnusa).

currently available, and new products regularly launched, this regulatory process could become overwhelming and costly.

**Conclusion:** CRN agrees that the increasing incidence of eating disorders and body dysmorphia among young people is a disturbing trend and encourages development of state, federal and local resources to address this public health crisis. We applaud legislators attempting to address this issue: however, targeting a regulated industry to limit access to safe and beneficial products is punitive and harmful to retailers and all consumers in Colorado. Dietary supplements are a supplement to, not a substitute for, a well-balanced diet and a healthy lifestyle. When used properly, they help promote overall good health and prevent disease. We welcome the opportunity to work with the Sponsors to develop an approach that captures illegal, dangerous products but doesn't punitively restrict access to thousands of beneficial products with no valid safety issues or dangerous ingredients.

TO: Colorado General Assembly

FROM: Susan J Hewlings PhD, RD

DATE: March 23, 2023

RE: Testimony in opposition to SB23-176

I am Dr. Susan Hewlings. I have a PhD in nutrition and a registered dietitian with advanced training in eating disorders treatment. I have over 25 years of experience in higher education, scientific research and clinical practice. My dissertation topic was eating disorder prevention for third and fourth grade girls. I owned and operated a private practice for ten years specializing in clients with eating disorders. Currently I am Vice president of Research Affairs at Radicle Science, an independent research organization serving the dietary supplement, food and beverage spaces. I help companies support their product development and marketing with science. In addition, I work with most of the major trade organizations in the dietary supplement industry as a scientific expert.

I respectfully oppose SB 23-176 as it is currently written. SB 23-176 would prohibit a retail establishment from selling, transferring, or otherwise furnishing dietary supplements for weight loss or over-the-counter diet pills to an individual under 18 years of age without a prescription—by requiring hundreds of products be restricted because of unjustified and unscientific concerns that they are tied to eating disorders. I agree that clinical and sub clinical eating disorders are a huge issue globally, with deadly consequences. However, restricting access to dietary supplements has no scientific basis, there is no support for a direct connection between dietary supplement use and eating disorders in the literature.

**More importantly, preventing access to such supplements may impede recovery efforts as dietary supplements are considered part of the nutrition treatment plan as described in the Academy of Nutrition and Dietetics: Revised 2020 Standards of Practice and Standards of Professional Performance for Registered Dietitian Nutritionists (Competent, Proficient, and Expert) in Eating Disorders.<sup>1</sup>**

The global prevalence rate for eating disorders in individuals aged 5 to 17 years is 4.4% of the population.<sup>2</sup> However, there is a much larger percentage of individuals of all ages, cultures and gender impacted by sub clinical eating disorders. A survey study of more than 4,000 women aged 25 to 45 years reported that 31% of women with no history of a diagnosis of anorexia or bulimia (clinical eating disorders) purged for weight control, and almost 75% report that body shape and weight concerns interfere with quality of life.<sup>3</sup> It can be assumed that these numbers are even higher now as a recent systematic review has demonstrated that the COVID-19 pandemic increased prevalence of eating disorders and disordered eating along with the increase in mental health issues.<sup>4</sup>

Clearly, we are experiencing an epidemic of body dissatisfaction and engagement of very dangerous unhealthy behaviors in an attempt to alter body shape. It is undisputed that eating disorders and the associated behaviors are a public health concern and measures must be taken to address this epidemic. Similar to any other public health concern it is critical to assess etiology and causation as well as related variables. In other words, a risk factor model must be applied, which has been done for major health concerns such as heart disease, depression, cancer, etc. This is an especially critical approach for any health issue that is multidimensional and complex such as eating disorders. For example, it is well

documented in the literature that eating disorders have many co morbidities and they often occur with mental health issues.

The Academy of Nutrition and Dietetics in their standards of practice for eating disorders states, “As a psychiatric condition with biopsychosocial mediators, each variant of an ED (eating disorder) will be impacted by four primary variables: temperament, genetics, environment, and malnutrition.” A critical aspect of treatment is to resolve the malnutrition early in recovery because the effects of malnutrition impact reasoning and cognitive capabilities which impedes the progress of treatment. Dietary supplements can assist in resolving malnutrition, especially in the beginning stages of treatment when it is challenging to consume food.

According to the Academy, another key aspect of treatment is to identify triggers. Those in support of this bill have stated that dietary supplement use is a trigger for eating disorders, despite a lack of evidence to support their statement, and in contrast to statements by major health organizations. A trigger is defined as “an antecedent that generates or provokes an ED behavior as a coping mechanism.” The Academy’s guidance goes on to state “Each ED client will have unique triggers that are specific to their underlying psychopathology. The nutrient composition of food, environmental variables such as location and smell, and dysfunctional relationships with people are common triggers.” Supplements are not mentioned as a common trigger and the emphasis is on the individual uniqueness of triggers. This suggests that it would be remiss to identify anything as a trigger for everyone and dietary supplements aren’t even listed as a primary or common trigger. It is mentioned in the guidelines for nutrition assessment that it is important to evaluate appropriate use of dietary supplements with more emphasis on intent of use and abuse of the substance. Furthermore, the Academy recognizes the importance of dietary supplements as part of the nutrition plan of care (section 3.13A).<sup>1</sup> **It should also be noted that it has been reported that among those with an eating disorder, the most frequently used or abused substances were not dietary supplements, they were alcohol, laxatives, emetics, diuretics, amphetamines/stimulants, and other drugs/substances.**<sup>5,6</sup>

As an expert I agree that eating disorders are a public health concern especially considering their co-occurrence with mental health issues. I agree that appropriate measures supported by scientific evidence need to be considered. However, putting forth restrictions that have no sound scientific basis and are against the standards of care of major professional organizations whose practitioners play a key role in treatment, is remiss and potentially harmful to those who suffer from eating disorders. I encourage efforts to address the risk factors identified in the literature and to provide resources accordingly.

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2. Erskine H, Baxter A, Patton G, et al. The global coverage of prevalence data for mental disorders in children and adolescents. *Epidemiology and psychiatric sciences*. 2017;26(4):395-402.

3. Reba-Harrelson L, Von Holle A, Hamer RM, Swann R, Reyes ML, Bulik CM. Patterns and prevalence of disordered eating and weight control behaviors in women ages 25-45. *Eating and weight disorders : EWD*. 2009;14(4):e190-198.
4. McLean CP, Utpala R, Sharp G. The impacts of COVID-19 on eating disorders and disordered eating: A mixed studies systematic review and implications. *Frontiers in psychology*. 2022;13:926709.
5. Naveed A, Dang N, Gonzalez P, et al. E-Cigarette Dependence and Weight-Related Attitudes/Behaviors Associated With Eating Disorders in Adolescent Girls. *Frontiers in psychiatry*. 2021;12:713094.
6. Association NED. Substance Use and Eating Disorders. 2022; <https://www.nationaleatingdisorders.org/substance-use-and-eating-disorders>. Accessed November 10, 2022.

**Kaitlin Whelan, MD, FAAP**  
**Testimony in Support of SB 23-176**  
**March 2023**

My name is Dr. Kaitlin Whelan, and I am a primary care pediatrician. I am testifying on behalf of myself and the American Academy of Pediatrics Colorado Chapter which represents nearly 800 pediatric providers in the state of Colorado. I ask for your support of Senate Bill 23-176.

Eating disorders are common. In fact, one in seven men and one in five women experiences an eating disorder by age 40, and in 95% of those cases, the disorder begins by age 25. In my own patient population and across the state, pediatricians and other pediatric professionals are seeing a rise in our young patients with eating disorders.

While these patients were once rarely seen in my primary care practice, weekly I now have multiple patients in my clinic who are being followed closely for the serious medical complications that can develop as a consequence of malnutrition, weight changes, or purging associated with eating disorders including hormonal dysfunction, dehydration, electrolyte abnormalities and lethal arrhythmias.

While patients with eating disorders are classically thought of as a certain body type, this is not the truth. When presenting with significant weight loss, but a BMI still classified in the “healthy,” overweight, or obese ranges, patients with eating disorders can be overlooked by health care providers and insurance companies. Yet, these patients may experience the same severe medical complications as those who are severely underweight and be unable to obtain the support they need. This bill helps protect them.

I have patient that abuses diet pills and laxatives as part of their eating disorder. As such, nasogastric tube (NGT) feeding may be necessary. This bill helps in this situation and would support those teens in need of this type of care. Potential benefits of NGT feeding include faster weight gain and medical stabilization, with a possibility for a reduced hospital length of stay.

Physicians involved in the treatment of medically unstable patients may need to provide nutrition via an NGT when nutritional needs are not being met. The use of IV or total parenteral nutrition carries higher risks of medical complications, is costly, and is not recommended. The goal of eating disorders is oral intake and that is always my goal but NGT may be used as part of treatment while patients work to get there.

Because of youth like my patient and for other patients who don't fit the misguided picture of an eating disorder, I ask for a vote in favor of Senate Bill 23-176. Thank you for your consideration.

Senate Health & Human Services

03/23/2023 01:30 PM

SB23-176 Protections For People With An Eating Disorder

Typed Text of Testimony Submitted

Name, Position, Representing	Typed Text of Testimony
Tara Topper For herself	<p>RE: BMI - I am a licensed psychotherapist who worked as a therapist for Eating Recovery Center from 2010-2016. In my six years working with over 500 patients recovering from anorexia or bulimia, I saw the added and unnecessary struggle patients faced in getting insurance approval for the length of stay they needed to truly heal from this debilitating disorder. The DSM-5 amended weight out as criteria for anorexia because it is not the primary driver of the illness, nor the only indicator. People can be above ideal body weight and be anorexic in mindset and behavior; people can start an ED without intent due to medical issues. Using BMI as the determining factor can give patients the false sense that, as long as they are above the BMI mark, they are well, which is not true and sets them up for a yoyo of leaving treatment too soon, thinking they're ready when they're not, going right back into ED behaviors because they never got to dismantle the trauma or temperament that drives the behavior, and then feeling shame that they've "failed" to recover. Then they come back for treatment only long enough to weight restore rapidly before getting kicked out for "succeeding" in weight restoration, or for being "too difficult" if they don't weight restore at the pace set for them. Either way, they don't get the help and time they need to recover. In the long run, it costs the insurance companies more to truncate treatment than to give a considerable length of stay the first time. This illness is largely misunderstood as one of vanity and, thus, is treated like a cosmetic issue, when it really is severe and fatal if left under treated. I believe it is critical to take away BMI as the determining factor for treatment. It is absolutely necessary to have treatment when someone is below that mark, but not sufficient as criteria and certainly not the mark to kick someone out. Insurance and third party payers must be held responsible to consider other factors, such as frequency of ED behaviors, level of subjective units of distress (SUDs) with trauma, psychological skill development, struggle with eating on one's own, etc. People struggling with an illness that is both an addictive process and a mental health challenge should not have to pay with their lives because their illness is misunderstood and they are denied the treatment they need.</p>
Alexia Giblin For Opal Clinic for Eating Disorders	<p>As a founder and director of an eating disorder treatment facility for the past 11 years, I am in full support of this bill. Health insurance companies often do not authorize or limit the number of authorized treatment days based on the patient's BMI rather than the presenting symptoms. As a clinician treating eating disorders for the past 20 years, an over reliance on weight data can cloud judgement. This bill would eliminate the systemic weight bias that has negatively impacted countless lives and allow for equitable access to eating disorder care.</p>

