

April 21, 2021

Dr. Terry Adirim
Acting Assistant Secretary of Defense for Health Affairs
Office of the Under Secretary of Defense for Personnel and Readiness
Department of the Defense
The Pentagon
Room 3E986
Washington, DC 20301

LTG Ronald J. Place
Director
Defense Health Agency
7700 Arlington Blvd, Suite 5101
Falls Church, VA 22042

Dear Acting Assistant Secretary Adirim and Director LTG Ronald Place:

On behalf of the Eating Disorders Coalition for Research, Policy & Action (EDC) and the REDC Consortium, we write to urge the Department of Defense (DoD), including the Defense Health Agency (DHA) to take actions to better identify, treat, and rehabilitate servicemembers and their family members affected by eating disorders. These actions can be administered through the implementation of the Senate FY 2021 National Defense Authorization Act (NDAA) [report language](#) (see page 232) based on the bipartisan SERVE Act, and addressing purchased-care provider contracting issues that affect access to care for servicemembers and their families.

The EDC is a nonprofit organization representing patient advocates, researchers, advocacy organizations, and families and individuals affected by eating disorders who collectively seek to make this mental illness a public health priority throughout the United States. The REDC Consortium is the national consortium of eating disorders treatment facilities focused on advancing standards, best practices, ethics, research, and policy.

Eating disorders are complex, serious mental illnesses affecting 28.8 million Americans¹ or 9% of the population during their lifetimes, regardless of age, sex, race, or ethnicity.² Eating disorders have the second highest mortality rate of any psychiatric condition, second only to opioid use disorder,³ accounting for 1 death every 52 minutes.⁴ The high mortality rate is caused by co-morbidities and suicide. When left untreated, eating disorders can lead to heart failure, kidney failure, osteoporosis, Type II diabetes, stroke, gastric rupture, hypoglycemia, other medical injury, and even death.⁵ Additionally, the suicide rate for those affected by eating disorders is 23 times higher than the rate for the general population.⁶

Eating disorders are also a costly condition; it is estimated that eating disorders cost the American economy \$64.7 billion each year, with families and individuals shouldering \$23.5 billion of that cost.⁷ Further, research shows the COVID-19 pandemic has significantly impacted those affected by eating disorders. This includes increases in restrictive behaviors for those affected by anorexia nervosa and binge eating behaviors for those affected by binge eating disorder and bulimia nervosa.⁸

¹ Deloitte Access Economics. The Social and Economic Cost of Eating Disorders in the United States of America: A Report for the Strategic Training Initiative for the Prevention of Eating Disorders and the Academy for Eating Disorders. June 2020. Available at: <https://www.hsph.harvard.edu/striped/report-economic-costs-of-eating-disorders/>.

² Ibid (1)

³ Arcelus, J., Mitchell, A.J., Wales, J., & Nielsen, S. (2011). Mortality rates in patients with anorexia nervosa and other eating disorders. A meta-analysis of 36 studies. *Archives of General Psychiatry*, 68(7), 724-731.

⁴ Ibid (1)

⁵ Jáuregui-Garrido, B. & Jáuregui Lobera, I. (2012). Sudden death in eating disorders. *Vascular Health and Risk Management*, 8, 91-98.

⁶ Harris, E.C. & Barraclough, B. (1997). Suicide as an outcome for mental disorders: a meta-analysis. *British Journal of Psychiatry*, 170(3), 205-228.

⁷ Ibid (1)

⁸ Termorshuizen, J., Watson, H., Thornton, L., Borg, S., Flatt, R., & MacDermid, C. et al. (2020). Early Impact of COVID-19 on Individuals with Eating Disorders: A survey of ~1000 Individuals in the United States and the Netherlands. *International Journal Of Eating Disorders*, 53(11), 1780-1790. doi: 10.1002/eat.23353

Servicemembers and their families experience these disorders at higher rates than their civilian peers. The Defense Health Board found that active-duty servicewomen are disproportionately impacted by eating disorders, directly affecting health and readiness.⁹ Risk factors associated with the military environment, including body shape and fitness standards, military sexual trauma, sexual harassment, weight stigmatization, and post-traumatic stress disorder (PTSD) all make servicemembers more likely to be affected by eating disorders.¹⁰ Military family members experience high rates of eating disorders as well, with studies showing 21% of children and 26% of spouses of servicemembers are symptomatic for an eating disorder, 3 times the rates of their civilian peers.¹¹ According to the DoD, 19,468 dependents of servicemembers received an eating disorder diagnosis from FY 2014 through FY 2018.¹² Last, an estimated 16% of female veterans have an eating disorder.¹³

However, unlike other psychiatric conditions, persons affected by eating disorders can rehabilitate with proper treatment, allowing them to be successful and active participants in society. We urge the DoD to consider implementing the below recommendations to improve the lives of servicemembers and their families affected by eating disorders.

Recommendations

I. FY 2021 Senate Report Eating Disorders Language Implementation:

On July 23, 2020, the Senate passed the FY 2021 NDAA, which included report language based on the bipartisan SERVE Act ([H.R. 2767/S. 2673](#)). The [report language](#) (page 232) encourages the DoD to eliminate the age restrictions that prevent military family members over the age of 20 from accessing residential eating disorders treatment, enact mental health early identification trainings for Commanding Officers and Supervisory Personnel, and ensure network adequacy for eating disorders treatment. The implementation of these provisions will help bridge the gaps in care and identification for servicemembers and their families.

Detailed below are recommendations on how to implement these provisions as well as other barriers experienced by servicemembers, their families, and the providers that care for them:

1. **Allowing Military Family Members Over 20 Years Old to Access Residential Eating Disorders Treatment:**
The average onset age of eating disorders ranges from 17 to 28 years old (with early onset between the age of 8 and 14 years old)^{14, 15}; however, TRICARE policies prohibit military family members over the age of 20 years old from receiving evidence-based, 24/7 residential eating disorders care. Conversely, there is no age restriction for a family member experiencing a substance use disorder to receive residential treatment.¹⁶ In turn, military and retiree adult children and spouses affected by the disorder are sent to inappropriate levels of care. Patients are either dropped to Partial Hospitalization Programs (PHP), which can spend down their limited 45-days of PHP care, or raised up to inpatient, which is clinically inappropriate and more costly to the Military Health System (MHS). Eating disorders have the highest average cost for inpatient stays (\$19,400) and longest length of stay (13.6 days) for any primary mental health diagnosis,¹⁷ so treating the disorder at the appropriate level of care will result in more suitable care for the TRICARE beneficiaries and be more cost effective for the MHS. The Congressional Budget Office recently

⁹ Parkinson, M. (2021). *Decision Brief: Active Duty Women's Health Care Services*. Defense Health Board.

¹⁰ Bartlett, B. and Mitchell, K., 2015. Eating disorders in military and veteran men and women: A systematic review. *International Journal of Eating Disorders*, 48(8), pp.1057-1069.

¹¹ Waasdorp, C. E., Caboot, J. B., Robinson, C. A., Abraham, A. A., & Adelman, W. P. (2007). Screening Military Dependent Adolescent Females for Disordered Eating. *Military Medicine*, 172(9), 962-967. doi:10.7205/milmed.172.9.962

¹² Armed Forces Health Surveillance Branch, Diagnoses of Eating Disorders, Active Component Service Members, U.S. Armed Forces, 2013-2017, Medical Surveillance Monthly Report, (Silver Spring, MD: June 2018), p. 18

¹³ Slane, J., Levine, M., Borrero, S., Mattocks, K., Ozier, A., Silliker, N., Bathulapalli, H., Brandt, C. and Haskell, S., 2016. Eating Behaviors: Prevalence, Psychiatric Comorbidity, and Associations With Body Mass Index Among Male and Female Iraq and Afghanistan Veterans. *Military Medicine*, 181(11), pp.e1650-e1656.

¹⁴ Rates of Help-Seeking in US Adults With Lifetime DSM-5 Eating Disorders: Prevalence Across Diagnoses and Differences by Sex and Ethnicity/Race Jaime A. Coffino, MPH, MA, Tomoko Udo, PhD, Carlos M. Grilo, PhD Mayo Clinic Proceedings Volume 94 Issue 8 Pages 1415-1426 (August 2019) DOI: 10.1016/j.mayocp.2019.02.030.

¹⁵ Herpertz-Dahlmann B, Dahmen B. Children in Need—Diagnostics, Epidemiology, Treatment and Outcome of Early Onset Anorexia Nervosa. *Nutrients*. 2019; 11(8):1932. <https://doi.org/10.3390/nu11081932>

¹⁶ Residential Substance Use Disorder Treatment | TRICARE. (2021). Retrieved from <https://tricare.mil/CoveredServices/IsItCovered/Residential-Substance-Use-Disorder-Treatment>

¹⁷ Owens PL (AHRQ), Fingar KR (IBM Watson Health), McDermott KW (IBM Watson Health), MuhuriPK (AHRQ), Heslin KC (AHRQ). Inpatient Stays Involving Mental and Substance Use Disorders, 2016.HCUP Statistical Brief #249. March 2019. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports/statbriefs/sb249-Mental-Substance-Use-Disorder-Hospital-Stays-2016.pdf

projected that expanding this coverage up to the age of Medicare eligibility would only cost \$2 million dollars over ten years, and expanding it to all ages would cost \$30 million dollars over 10 years. **We recommend DoD implement the Senate report provisions by expanding TRICARE policies to permit military families over the age of 20 years old to receive residential eating disorders treatment.**

2. **Training Commanding Officers and Supervisory Personnel to Early Identify Mental Illnesses for Referrals:** Commanding Officers and Supervisory Personnel are not provided relevant resources or training on how to identify the signs and symptoms of mental illnesses, including eating disorders. Yet, these leaders must give approval when their direct report seeks inpatient level mental health treatment. When mental illnesses, particularly eating disorders, are left untreated they become more severe and less receptive to treatment.¹⁸ For example, one study demonstrated that those who received treatment within the first 5 years of bulimia had a recovery rate of 80%, whereas those who waited more than 15 years to get treatment experienced recovery rates closer to 20%.¹⁹ **We recommend DoD implement the Senate report provisions by requiring Commanding Officers and Supervisory Personnel to be trained to early identify mental illness. This will not only aid the command of their units, but also inform their recommendations for care.**

3. **Improving Network Adequacy for Eating Disorders Care:** Only about one-fifth of the nationwide eating disorders care is available to servicemembers and their families in-network under TRICARE.²⁰ This limited access requires servicemembers and their families to travel out of state for care, take on significant debt to pay for care, or make the tough decision to receive inappropriate care or forgo treatment all together. In comparison to the overall available care in the United States, TRICARE only contracts with 35% (in-network and out-of-network) of the 365 available treatment facilities in the nation.²¹ This highlights a lack of access to care for our servicemembers and their families in comparison to the civilian population. **We urge DHA to ensure networks are open for contracting to improve network adequacy and remove administrative and contracting barriers for all levels of eating disorders care, including inpatient, residential treatment, partial hospitalization programs, intensive outpatient programs, and outpatient services including Medical Nutrition Therapy (MNT), also known as dietitian services.**

The recommendations below detail how DHA can work to further improve network adequacy for eating disorders care:

- a. **Expand Coverage for Dietitian Services Beyond Anorexia Nervosa:** Currently, coverage for MNT or dietitian services is only available to those affected by anorexia nervosa under TRICARE.²² This is problematic, as MNT has been identified by experts as one of the four necessary components of a successful eating disorders treatment and recovery process. This is true not just for anorexia nervosa, but for all eating disorder types, including bulimia nervosa and the most common military eating disorder, binge eating disorder.²³ Additionally, some Military Treatment Facility (MTF) dietitians recently reached out to the EDC describing a surge in eating disorders on installations and requesting additional training on how to address eating disorders. **Considering medical complications of untreated or poorly treated eating disorders can include heart failure, kidney failure, osteoporosis, Type II diabetes, stroke, gastric rupture, hypoglycemia, other medical injury, and death,²⁴ we urge DHA to expand coverage for dietitian services to all eating disorder types.**

¹⁸ Becker, A., Franko, D., Nussbaum, K., & Herzog, D. (2004). Secondary prevention for eating disorders: The impact of education, screening, and referral in a college-based screening program. *International Journal Of Eating Disorders*, 36(2), 157-162. doi: 10.1002/eat.20023

¹⁹ Reas, D. L., Williamson, D. A., Martin, C. K. and Zucker, N. L. (2000), Duration of illness predicts outcome for bulimia nervosa: A long-term follow-up study. *Int. J. Eat. Disord.*, 27: 428-434. doi:10.1002/(SICI)1098-108X(200005)27:4<428::AID-EAT7>3.0.CO;2-Y

²⁰ Of the 365 facilities nationwide, eating disorder specialized care was available in 248 IOPs, 222 PHPs, 112 RTCs, and 55 inpatient facilities. In turn, TRICARE contracts with 33% of IOPs, 36% of PHPs, 30% of RTCs, and 55% of inpatient facilities.

²¹ New GAO Report Shines Light on DOD's Lack of Screening and Early Identification for Eating Disorders and Insufficient Access to Care. (2021). Retrieved from <http://eatingdisorderscoalition.org.s208556.gridserver.com/couch/uploads/file/gao-report-statement-10-20.pdf>

²² Nutritionist or Dietician Services | TRICARE. (2021). Retrieved from <https://tricare.mil/CoveredServices/IsItCovered/Nutritionist>

²³ Eating Disorders in the Military - Center For Discovery. (2021). <https://centerfordiscovery.com/blog/eating-disorders-military/>

²⁴ Jáuregui-Garrido, B. & Jáuregui Lobera, I. (2012). Sudden death in eating disorders. *Vascular Health and Risk Management*, 8, 91-98.

- b. **Resolve Overdue Payment Issues:** Purchased-care eating disorder treatment facilities from the TRICARE East region have consistently reported issues with overdue payments. These issues include repayment delays for services rendered as far back as 2019, which is beyond the 30-day deadline required by federal law, as well as partial payments, and incorrect payment rates when claims are paid. **We recommend DHA work to resolve these payment issues to ensure interest does not continue to accrue and providers stay within the TRICARE network.**
- c. **Regularly Update the TRICARE Provider Directories:** A 2020 Government Accountability Office (GAO) report on eating disorders in the military lists 166 in-network and out-of-network facilities in 32 states where eating disorders treatment is available.²⁵ However, after careful research and analysis, the EDC found that out of the list of 166 facilities for eating disorders care, 40 facilities (24%) listed were incorrect and not available for eating disorders care, and three facilities were not listed as available for care.²⁶ Consequently, there are only 129 facilities in 26 states available to treat eating disorders, of which only 79 facilities in 20 states are in-network with TRICARE and only 58 (45%) in-network facilities treat adults.²⁷ ²⁸ When servicemembers and their family members face provider directory inaccuracies while trying to seek care, they can become discouraged and either pursue costly care outside of the TRICARE system or give up on pursuing care entirely. This is unfortunately emblematic of the difficulty accessing care across mental health issues, as a DoD Inspector General report states that 53% of active duty servicemembers and their families who were referred to TRICARE for mental health care never received care.²⁹ **We recommend DHA and TRICARE East and West create mechanisms to ensure that the provider directories are accurate for TRICARE beneficiaries.**
- d. **Create a Complaint Tool for Servicemembers/Beneficiaries and Providers:** The 2020 GAO report on eating disorders stated, “According to DHA data for years 2018 through 2019, no access to care complaints related to eating disorder treatment were reported by TRICARE beneficiaries.”³⁰ However, servicemembers, their families, and providers do not have a means of reporting challenges or complaints regarding access to care via TRICARE East and West. This points toward the need for a complaint mechanism, so DHA can be made aware of issues in a timely manner, and action can be taken on urgent issues such as challenges in accessing mental health care. **We urge DHA to create a tool for beneficiaries and providers to report concerns about TRICARE coverage, denials, inaccurate provider directories, network adequacy, overdue or incorrect payments, and other related issues.** There is precedent in the federal system for complaint systems. For example, see the Centers for Medicare and Medicaid Services (CMS) HIPAA complaint portal.³¹ The mechanism should follow a straightforward flow chart for filing complaints and include accountability for addressing complaints according to the level of urgency.
- e. **Improved Purchased-Care Provider Payments:** Another barrier to quality care is that the reimbursement rates for TRICARE are poorly distributed and much lower than the reimbursement rates on the commercial side of care. For example, Partial Hospitalization Programs (PHPs), which is considered a full day of care (averaging 6-12 hours per day) the TRICARE maximum rate is up to \$449 per day. However, Intensive Outpatient Programs (IOPs), which is considered a half day of care (averaging 3-4 hours per day), maximum TRICARE maximum rate is up to \$337 per day.³² This translates to only a 33% increase in cost for up to an additional 8 hours of care. Additionally, both of these maximum rates are below the reimbursement rates offered in the commercial setting. **We urge DHA to restructure provider rates for mental health IOP**

²⁵ Government Accountability Office. (2020). Department of Defense: Eating Disorders in the Military. Retrieved from <https://www.gao.gov/assets/710/708697.pdf>

²⁶ 19.3% or 32 centers did not actually provide eating disorders care, 3% or five centers did not exist, and 1.8% or three centers were duplicates on the reported list. 19.3% or 32 centers did not actually provide eating disorders care, 3% or five centers did not exist, and 1.8% or three centers were duplicates on the reported list.

²⁷ EDC’s research and analysis found that of the 131 facilities available for care, the following was available based on level of care: 83 IOPs, 81 PHPs, 34 RTCs, and 28 inpatient facilities.

²⁸ A total of 79 facilities treating eating disorders were in-network with TRICARE, including 47 IOP, 63 PHP, 24 RTCs, and 11 inpatient. Additionally, only 97 of the 129 facilities that are TRICARE contracted both in-network and out-of-network treat adults, with 71 IOPs, 79 PHPs, 19 RTCs, and 18 inpatient

²⁹ Department of Defense Office of Inspector General. (2020). *Evaluation of Access to Mental Health Care in the Department of Defense (DODIG-2020-112)*. Retrieved from <http://dodig.mil/reports.html/Article/2309785/evaluation-of-access-to-mental-health-care-in-the-department-of-defense-dodig-2/>

³⁰ Ibid (22)

³¹ <https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Enforcements/FileaComplaint>

³² Table Of Maximum Rates For Freestanding Psychiatric Partial Hospitalization Programs (PHPs) Reimbursement - FY 2019 - FY 2021. (2021). Retrieved from <https://health.mil/Military-Health-Topics/Business-Support/Rates-and-Reimbursement/MHSUD-Facility-Rates>

and PHP care, and consider increasing provider rates to be closer in line with commercial plans to improve network adequacy.

II. Other Relevant Issues Not Included in the NDAA:

1. **Training Health Professionals on Eating Disorders:** Despite the fact that eating disorders affect servicemembers and their family members at higher rates than the civilian population, training around eating disorders care is limited in the military. Direct care providers are not trained according to generally accepted standards of care for health practitioner identification of eating disorders. Medical standards of care for health practitioner identification of eating disorders are robust, and include a combination of physical and neuropsychiatric signs, according to the Academy for Eating Disorders' (AED) Medical Care Standards Guide.³³ Overall, only 20% of surveyed medical residency programs offer elective training in eating disorders, with 6% requiring such training.³⁴ Identification is a key component of accepted SBIRT (screening, brief intervention and referral to treatment) protocol, and should not be overlooked in the care setting.

Additionally, the Defense Health Board reports that variability in screening protocols in the military result in stark differences in the reported prevalence of diagnosed eating disorders.³⁵ Standardized training is needed to reduce the variability in screening protocols that result in the differences in reported prevalence rates of diagnosed eating disorders and promote early interventions to prevent eating disorders from continuing to impact the health and readiness of active-duty women. The VA has seen such a rise in eating disorders cases that they are now working to train all their health professionals on eating disorders, and we believe DHA should be doing the same. **We recommend that DHA work in the development and provision of these trainings and implement Defense Health Board recommendations to systematize screening across all branches.**

2. **Adjust Body Composition Test to Avoid Inadvertently Encouraging Disordered Eating:** All services use body fat content screening procedures and equations, called the body composition test through the Physical Fitness and Body Fat Programs to measure the health and readiness of servicemembers. This test relies on Body Mass Index (BMI) testing, evaluating body weight against a servicemembers' height. While the branches vary on the BMI range for a "healthy weight" for testing, when a servicemember falls outside of these BMI values, a secondary test called a circumference test or "belt test" is conducted. This test is used to evaluate whether the servicemember passes the test, they are flagged, and if remediation is unsuccessful, they may become ineligible for promotion, various trainings, schools, or even be subject to separation.

Research has demonstrated that BMI and the circumference tests, particularly for individuals with more muscle mass, are not adequate measures of health, body fat percentage, or fitness and can lead to situational eating disorders (i.e. extreme behaviors to achieve rapid weight loss) or an eating disorder.³⁶ Throughout the years, the EDC has received reports from servicemembers of all genders engaging in dangerous disordered eating behaviors and weight loss behaviors to pass fitness tests and developing eating disorders as a result of testing. **Accordingly, we recommend that the DoD update the Body Composition Testing to align with science-based contemporary health and fitness measurements. We welcome the opportunity for the eating disorder community to provide input on improvements to the program so that it more accurately addresses the needs of military readiness while also protecting the physical and behavioral health of servicemembers.**

3. **Increasing Research on Servicemembers and Families Eating Disorders:** Since the FY 2017 Congressional inclusion of eating disorders as a topic area of research, the Congressionally Directed Medical Research Program's Peer Reviewed Medical Research Program (PRMRP) has funded over \$25 million in research on eating disorders in the military, military families, and veterans. These research topics have included risk factors, co-morbidities, and

³³ Medical Care Standards Guide - The Purple Book. (2020). Retrieved 8 October 2020, from <https://www.aedweb.org/resources/onlinelibrary/publications/medical-care-standards>

³⁴ Mahr, F., Farahmand, P., Bixler, E., Domen, R., Moser, E., & Nadeem, T. et al. (2014). A national survey of eating disorder training. *International Journal Of Eating Disorders*, 48(4), 443-445. doi: 10.1002/eat.22335

³⁵ Ibid (6)

³⁶ Nuttall, Frank Q. MD, PhD Body Mass Index, *Nutrition Today*: May/June 2015 - Volume 50 - Issue 3 - p 117-128 doi: 10.1097/NT.000000000000092.

binge eating among military members. **We applaud this work, and urge further investment in this research to address military-specific issues, such as research to elucidate how eating disorders may present differently in the military family, anonymous surveillance of eating disorders in servicemembers and their families to understand the full scope and risk, clarifying “situational” eating disorders in relationship to servicemembers body composition programs and fitness tests, and understanding stigma related to eating disorders and other barriers to seeking treatment.**

4. **Adverse Event Reporting for Dietary Supplements for Weight Loss and Muscle Building:** 70% of servicemembers use dietary supplements, 20% higher than the rate in the civilian population,³⁷ with 22% of servicemembers reporting they consume three or more supplements per week.³⁸ The most common dietary supplements consumed within this population are for muscle-building, physical performance, and energy, which are three times more likely to cause severe medical injury than vitamins.³⁹ Adverse events associated with dietary supplement use include organ failure, heart attack, stroke, seizure, tremors, and other medical injury including death.^{40,41,42,43}

Diet pill use for weight control is also linked with a vastly increased risk of an eating disorders diagnosis within 1-3 years of beginning supplement use.⁴⁴ An eating disorder, in addition to the other adverse events listed above, can ultimately threaten a servicemember’s readiness if they or military health personnel are not properly informed about dietary supplements and eating disorders. Although 60% of military physicians have observed adverse events linked with supplement use in servicemembers, fewer than 30% of the physicians know how to report an adverse event.⁴⁵

Adverse event reporting is already required within the military for medications and heat-related illnesses. **We recommend the DoD include adverse event reporting for dietary supplements for weight loss and muscle building and connecting that reporting with the FDA’s adverse event reporting system to assist in military readiness, protect the health of servicemembers, and ensure the safety of the nation.**

The EDC and REDC Consortium urge you to take the recommended actions above and welcome the opportunity to meet to further discuss these issues in detail. Doing so would vastly improve access to eating disorders care for the 9.5 million servicemembers and beneficiaries on TRICARE. To further discuss this issue and schedule a meeting, please reach out to Katrina Velasquez at kvelasquez@eatingdisorderscoalition.org.

Sincerely,



Chase Bannister, MDIV, MSW, LCSW, CEDS
President, Board of Directors
Eating Disorders Coalition for Research,
Policy & Action



Jillian Lampert
President
REDC Consortium

³⁷ Pew Charitable Trusts. (October 2017). Dietary Supplement Use in the Military. Retrieved from https://www.pewtrusts.org/-/media/assets/2017/10/hcp_dietary_supplement_use_in_the_military_final.pdf

³⁸ Ibid.

³⁹ Or F, Kim Y, Simms J, Austin SB. Taking stock of dietary supplements' harmful effects on children, adolescents, and young adults. *Journal of Adolescent Health*. 2019;65(4):455-461.

⁴⁰ Pew Charitable Trusts. (October 2017). Dietary Supplement Use in the Military. Retrieved from https://www.pewtrusts.org/-/media/assets/2017/10/hcp_dietary_supplement_use_in_the_military_final.pdf

⁴¹ Abdel-Rahman A, Anyangwe N, Carlucci L, Caspar S, Danam RP, Enongene E, Erives G, Fabricant D, Gudi R, Hilmas CJ, Hines F, Howard P, Levy D, Lin Y, Moore RJ, Pfeiler E, Thurmond TS, Turujman S, Walker NJ. The safety and regulation of natural products used as foods and food ingredients. *Toxicological Sciences*. 2011 ;123(2):333-348.

⁴² Li N, Hauser R, Holford T, et al. Muscle-building supplement use and increased risk of testicular germ cell cancer in men from CT and MA. *British Journal of Cancer*. 2015;112:1247-1250.

⁴³ Abdel-Rahman A, Anyangwe N, Carlucci L, Caspar S, Danam RP, Enongene E, Erives G, Fabricant D, Gudi R, Hilmas CJ, Hines F, Howard P, Levy D, Lin Y, Moore RJ, Pfeiler E, Thurmond TS, Turujman S, Walker NJ. The safety and regulation of natural products used as foods and food ingredients. *Toxicological Sciences*. 2011 ;123(2):333-348.

⁴⁴ Levinson, J., Sarda, V., Sonnevile, K., Calzo, J., Ambwani, S., & Austin, S. (2020). Diet Pill and Laxative Use for Weight Control and Subsequent Incident Eating Disorder in US Young Women: 2001–2016. *American Journal Of Public Health, 110*(1), 109-111. doi: 10.2105/ajph.2019.305390

⁴⁵ Deuster P, Lieberman H. Protecting military personnel from high risk dietary supplements. *Drug Testing and Analysis*. 2016;8: 431-433