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VA HEALTH CARE

Status of Key Recommendations Related to Mental Health and Medication Management

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GAO Highlights

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GAO-26-108786 December 2025

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What GAO Found

The Department of Veterans Affairs (VA) provides health care services to over 9 million enrolled veterans, and thousands of military service members transition to its care each year. Mental health conditions are a persistent issue for veterans, and many veterans also live with chronic pain. These conditions are often treated with medications that must be managed carefully. For example, opioids can be prescribed for pain, but these carry the risk of addiction and overdose.

VA has implemented four key GAO recommendations to strengthen its oversight of mental health treatment plans and to help ensure its providers follow strategies for mitigating the risk of opioids.

- **Mental health treatment plans.** Veterans with mental health conditions may be offered various treatment options, including medication or therapy, or a combination of both. The Veterans Health Administration (VHA) requires specialty providers, such as psychiatrists, to document in mental health treatment plans that evidence-based treatment options were considered. In June 2019, GAO found VHA did not have guidance for these requirements nor monitor whether the providers followed them. VA concurred with GAO's two recommendations to address these issues and, in 2020, implemented both. For example, VA initiated reviews of selected charts biannually to ensure providers meet mental health treatment planning expectations.
- **Opioid safety risk mitigation strategies.** In response to concerns about opioid use, VA launched its Opioid Safety Initiative in 2013 to help ensure veterans are prescribed and use opioids in a safe and effective manner. As part of this initiative, VHA developed risk mitigation strategies for providers to follow when prescribing opioids to veterans, such as conducting urine drug screening. In May 2018, GAO found VHA providers at selected medical facilities did not consistently follow some risk mitigation strategies. Further, not all facilities had access to trained providers to educate other providers in ensuring opioid safety. GAO made two recommendations to address these issues. VA concurred and, in 2019 and 2020, implemented each recommendation. For example, VA created a planning tool that gives providers information on risk mitigation strategies, such as the patient's last urine screening.

VA has not addressed GAO's recommendation to the Department of Defense-VA Joint Executive Committee to assess the effectiveness of mental health services for transitioning service members and veterans. This Committee oversees the two departments' coordination for health care and benefits, including programs that may assist service members and veterans during the transition. In 2024, GAO found that the Committee had identified a number of mental health touchpoints for transitioning service members. However, the Committee had not assessed the effectiveness of the departments' efforts in facilitating access to such mental health touchpoints and made a recommendation that it do so. VA concurred with this recommendation, but as of November 2025, this recommendation has not yet been implemented.

Why GAO Did This Study

Effective medication management is of the utmost importance to ensure U.S. veterans receive safe and comprehensive treatment as part of their health care. This is particularly important for the growing number of veterans receiving treatment for mental health conditions and for vulnerable populations, such as those transitioning out of the military.

Concerns have been raised about the adverse effects of polypharmacy among veterans, which is the use of more than one medication. For example, research suggests that prescribing both benzodiazepines—a type of medication used to treat anxiety or post-traumatic stress disorder—and opioids to treat chronic pain can increase veterans' risk of death from suicide.

GAO has reported on opportunities for VA to enhance its oversight of various issues related to medication management for veterans, including those with mental health conditions and those transitioning out of the military. This statement describes a selection of this work, including recommendations GAO has made related to (1) mental health treatment plans, (2) opioid safety, and (3) access to mental health services for transitioning service members and veterans.

This statement is based primarily on three GAO reports issued between May 2018 and July 2024 (GAO-18-380, GAO-19-465, and GAO-24-106189). GAO also reviewed available research related to VA prescribing practices and steps the agency has taken to address five selected recommendations GAO made across these reports.

Chairman Moran, Ranking Member Blumenthal, and Members of the Committee:

Thank you for the opportunity to discuss issues related to the Department of Veterans' Affairs (VA) medication management. Effective medication management is of the utmost importance to ensure our nation's veterans receive safe and comprehensive treatment as part of their health care, including for mental health conditions.

Mental health conditions have been a persistent and growing issue for our nation's veterans.[1] From 2006 through 2023, the number of veterans who received mental health care from the Veterans Health Administration (VHA) more than doubled, according to VHA officials. Veterans with mental health conditions can receive treatment through psychotropic medications, such as anti-depressants or mood stabilizers. Treatments may also include non-pharmacologic therapy, such as talk therapy, or using a combination of medication and therapy.

Additionally, more than a third of veterans lived with chronic pain in 2023, often because of injuries from their military service, according to VA. One common treatment for chronic pain is the use of opioid medications, which can result in addiction as well as potentially overdose and death, if not managed appropriately.[2] Our past work has shown that veterans are particularly at risk for developing substance use disorders and they are 1.5 times more likely to die from opioid overdose than the general population.[3] In response to concerns about opioid use, VA launched its Opioid Safety Initiative in 2013 to help ensure veterans are prescribed and use opioid pain medications in a safe and effective manner.

[1]For the purposes of our report, mental health conditions include various conditions such as anxiety-related disorders, depression-related disorders, and post-traumatic stress disorder, as well as substance use disorders such as alcohol use disorder.

[2]Drug misuse—the use of illicit drugs and the misuse of prescription drugs, including opioids—has been a persistent and long-standing public health issue in the U.S. In September 2025, the Department of Health and Human Services renewed, as it has done since the initial 2017 determination, the declaration of the opioid crisis as a public health emergency. We added national efforts to prevent, respond to, and recover from drug misuse to our High-Risk List in 2021. See GAO, *High-Risk Series: Heightened Attention Could Save Billions More and Improve Government Efficiency and Effectiveness*, GAO-25-107743 (Washington, D.C.: Feb. 25, 2025) for our most recent update on progress federal agencies have made on this issue.

[3]See GAO, *Veterans Health Care: Services for Substance Use Disorders, and Efforts to Address Access Issues in Rural Areas*, GAO-20-35 (Washington, D.C.: Dec. 2, 2019).

Media reports have highlighted concerns about polypharmacy among veterans, which is the use of more than one medication that may have adverse effects when combined.[4] Polypharmacy can result in overdose or death. Research suggests that prescribing both opioids and benzodiazepines—a type of medication used to treat anxiety or post-traumatic stress disorder—can increase veterans' risk of death from suicide.[5] However, some veterans have multiple chronic and mental health conditions, which may necessitate the use of numerous medications, increasing the risk of polypharmacy. For example, some veterans with post-traumatic stress disorder (PTSD) may be prescribed more than one medication, such as medicines to improve sleep and anxiety, which, if managed improperly, could lead to adverse health outcomes or even overdose or death. As such, it is critical that VA ensure it is offering effective treatment options, including both medication and non-pharmacologic options, to reduce the risk of adverse health outcomes.

Furthermore, some populations of veterans are particularly vulnerable to developing mental health conditions. One such population includes the thousands of military service members transitioning back to civilian life annually. The transition period can bring challenges, such as the loss of a sense of purpose, familial and financial strain, and difficulty readjusting to social and civilian life.[6] Research has shown that during the transition period, service members are particularly vulnerable to mental health conditions. For example, the suicide rate is about 2.5 times higher for veterans in the first year of separation than for active-duty service

[4]For example, see Shalini Ramachandran and Betsy McKay, "Combat Cocktail: How We Overmedicate Veterans," *Wall Street Journal*, August 2, 2025.

[5]National Academies of Sciences, Engineering, and Medicine, *Veterans, Prescription Opioids and Benzodiazepines, and Mortality, 2007–2019: Three Target Trial Emulations* (Washington, D.C.: 2025).

[6]More than 210,000 service members separated in fiscal year 2023, according to data from the Department of Defense (DOD). DOD separation data include active-duty service members from the Army, Air Force, Marines, Navy, and Coast Guard. They also include Reserve and National Guard separations from active duty greater than 180 days or on contingency operations orders over 30 days.

members.[7] VA, in coordination with the Department of Defense (DOD), has a number of programs and processes, such as pre-separation counseling and health assessments, to provide mental health services to service members and veterans as they transition out of the military.

Over the past several years, we have reported on opportunities for VA to enhance its oversight of various issues related to medication management for veterans, including those with mental health conditions and vulnerable populations, such as those transitioning out of the military. My testimony today summarizes selected findings from a selection of this body of work, including key recommendations we have made related to

1. providing guidance on and monitoring mental health treatment plans for veterans;
2. ensuring provider adherence with key opioid risk mitigation strategies; and
3. assessing transitioning service members' and veterans' access to mental health services.

This statement is based on work we issued between May 2018 and July 2024 reviewing prescribing practices for mental health conditions, opioid safety, and access to mental health services for transitioning service members.[8] Detailed information on the objectives, scope, and methodology of this work can be found in each issued report. This statement is also based on our review of available research related to VA

[7]See Yu-Chu Shen, Jesse M. Cunha, Thomas V. Williams, "Time-Varying Associations of Suicide with Deployments, Mental Health Conditions, and Stressful Life Events Among Current and Former U.S. Military Personnel: A Retrospective Multivariate Analysis," *Lancet Psychiatry*, vol. 3, no. 11 (2016):1039-1048. This study showed that the suicide rate remained about 2.5 times higher for veterans in the first 3 years of separation compared with the active-duty population. This risk for death by suicide can remain elevated for years following the transition period.

[8]See GAO, *VA Mental Health: VHA Improved Certain Prescribing Practices, but Needs to Strengthen Treatment Plan Oversight*, GAO-19-465 (Washington, D.C.: June 17, 2019); *VA Health Care: Progress Made Towards Improving Opioid Safety, but Further Efforts to Assess Progress and Reduce Risk Are Needed*, GAO-18-380 (Washington, D.C.: May 29, 2018); and *DOD and VA Health Care: Actions Needed to Better Facilitate Access to Mental Health Services During Military to Civilian Transitions*, GAO-24-106189 (Washington, D.C.: July 15, 2024).

prescribing practices and information on the agency's efforts to implement five key recommendations GAO made in these reports.[9]

We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

VA operates one of the nation's largest health care systems. Its health care system is organized into 18 regional networks, called Veterans Integrated Service Networks, that oversee 170 VA medical centers and more than 1,000 outpatient facilities. These networks serve over 9 million enrolled veterans.[10] These facilities, in turn, deliver a wide range of health care services to veterans including traditional hospital-based services (e.g., surgery and pharmacy) and specialty services (e.g., psychiatry). To meet the needs of the veterans it serves, VA is also authorized to pay for eligible veterans to receive medical care from providers in the community.[11]

VA Mental Health Treatment

According to VA data, 31 percent of all users of VHA services in 2023 had a confirmed mental health diagnosis.[12] VA also found that 14 percent of

[9]See, for example, Alessandra A. Pratt et al., "The Impact of Comorbid Chronic Pain on Pharmacotherapy for Veterans with Post-Traumatic Stress Disorder," *Journal of Clinical Medicine,* vol. 12, no.14 (2023): 4763, and Kenda R. Stewart Steffensmeier et al., "What's Gender Got to Do With It: Accounting for Differences in Incident Guideline Discordant Prescribing for PTSD Among Women and Men Veterans, *Journal of Clinical Psychiatry,* vol. 85, no. 2 (2024).

[10]We have made over 200 recommendations since 2010 for VA to improve its oversight of the safety, quality, and timeliness of veterans' health care. As a result of these longstanding issues, we added VA health care to the GAO High-Risk List in 2015, and noted that inadequate oversight and accountability was an area of concern. See GAO, *High-Risk Series: An Update*, GAO-15-290 (Washington, D.C.: Feb. 11, 2015).

[11]See VA MISSION Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393, 1395-1404 (2018).

[12]Department of Veterans Affairs, *From Science to Practice: Mental Health Conditions Among VHA Patients* (Washington, D.C.: April 2024).

all users of VHA services in that year had a PTSD diagnosis.[13] Veterans with PTSD or other mental health conditions may be offered a variety of treatment options. This includes non-pharmacologic therapy, such as talk therapy, and pharmacologic therapy, such as medication, or a combination of both.

In our prior work, VA medical center officials we interviewed reported that various factors contribute to providers' decisions to prescribe psychotropic medications and offer non-pharmacologic therapy to veterans.[14] Specifically, these officials from multiple VA medical centers cited each of the following factors: VA medical center resources, the complexity of veterans' mental health conditions, the comfort level of providers with treating conditions or prescribing medications, the veterans' preferences, and the logistics of receiving mental health treatment.

VA Mental Health Treatment Planning Requirements

Having a treatment plan for each veteran with a diagnosed mental health condition is essential for ensuring that the veteran receives coordinated, individualized care that reflects the VA provider's consideration of all appropriate treatment options in alignment with the veteran's specific clinical needs and recovery goals. VHA has established certain requirements for mental health specialists' documentation of mental health care treatment plans. The Joint Commission—an independent, not-for-profit organization that accredits and certifies health care organizations including VA medical centers—is to periodically review the documentation of such plans to ensure that they align with the Commission's standards.

- **VHA policies to document mental health treatment plans.** In 2008, VHA issued its mental health services handbook to define minimum clinical requirements for mental health services at VA medical centers, requiring that specialist mental health providers, such as psychiatrists, document mental health treatment plans in veterans' electronic

[13]VA's data from 2023 are consistent with our prior reporting, which found that PTSD was one of the most prevalent mental health conditions, with 12 percent of veterans using VHA services in 2018 having a PTSD diagnosis. We reported that the other most highly prevalent mental health conditions included major depressive disorder (15 percent) and generalized anxiety disorder (3 percent). See GAO-19-465.

[14]GAO-19-465.

medical records.[15] The mental health services handbook specifies that plans should include documentation that different evidence-based treatment options were considered by mental health providers and that approaches to monitor the outcomes of care were developed.[16]

- **The Joint Commission standards for mental health care settings.** As part of the accreditation process for VA medical centers, the Joint Commission assesses mental health treatment plans developed by specialty care providers based on various standards. These standards focus on specific patient and organization functions that are essential to providing safe and high-quality care, including plans for treatment provided in mental health care settings.

VA Opioid Safety Initiative and Risk Mitigation Strategies

VA launched its Opioid Safety Initiative in 2013 to improve the safety and care of veterans who are prescribed opioids for pain. Part of its efforts include using non-pharmacologic pain relief alternatives, such as acupuncture or yoga, for veterans. As part of this initiative, VHA developed three opioid risk mitigation strategies for its providers to follow when prescribing opioid pain medications to veterans.

- **Annual urine drug screening for veterans on long-term opioid therapy.** Providers should generally ensure that an annual urine drug screening has been conducted for veterans who are on long-term opioid therapy prior to initiating or renewing an opioid prescription.[17]
- **Annual prescription drug monitoring program (PDMP) query.** PDMPs are state-run electronic databases used to track dispensing of prescriptions for controlled substances, identify suspected misuse or diversion, and identify trends in drug utilization. In 2016, VHA began requiring that providers query these programs at least annually when

[15]According to VHA officials, the mental health services handbook's planning requirements for mental health treatment do not apply to mental health providers who create treatment plans in a primary care setting through the primary care-mental health integration (PC-MHI) model.

[16]Evidence-based treatments are those that have been scientifically studied and proven to be effective for the treatment of a mental health condition. The mental health services handbook includes additional mental health treatment plan requirements that elaborate on this component, such as that mental health treatment plans must consider treatment options intended to reduce symptoms, improve functioning, prevent relapses or recurrences of episodes of illness, and be attentive to the veteran's values and preferences.

[17]VHA defines long-term opioid therapy as having had a 90-day supply or more of opioids in the last 6 months.

prescribing opioids to determine if the veteran has obtained opioid medications or other controlled substances from a non-VA provider.[18]

- **Informed consent for long-term opioid therapy.** In 2014, VHA issued a policy requiring that providers educate their patients on the risks associated with the use of prescription opioids and obtain veterans' formal acknowledgment of these risks in writing.[19]

Military to Civilian Transition

The transition from military to civilian life can be a particularly vulnerable period for veterans. Upon entering civilian life, veterans may have difficulty translating their military skills to a civilian job, and they may struggle to find employment, housing, and the other benefits that were provided as part of their military service. VA's research has identified many transition-related challenges—such as homelessness, family reintegration, employment, post-traumatic stress disorder, and substance misuse—that can increase the risk for suicide during the first year after separation.[20]

[18]Veterans Health Administration, *Querying State Prescription Drug Monitoring Programs*, VHA Directive 1306 (Washington, D.C.: Oct. 19, 2016). This requirement is subject to limitations imposed by states, which can impact VHA providers' access to the state databases. According to VHA policy, providers should follow state regulations for queries if these regulations are more stringent than VHA's policy.

[19]In December 2023, VA issued an updated policy related to informed consent for clinical treatments and procedures that incorporated the requirements of the 2014 policy on long-term opioid therapy for pain. See Veterans Health Administration, *Informed Consent for Clinical Treatments and Procedures*, VHA Directive 1004.01(3) (Washington, D.C.: December 12, 2023).

[20]Academic research also found that certain demographic characteristics, such as length of time in service and level of education, can exacerbate these challenges. For example, see Chandru Ravindran, et al., "Association of Suicide Risk with Transition to Civilian Life," *JAMA Network Open*, vol. 3, no. 9 (2020).

Providing Guidance on and Monitoring Providers' Documentation of Required Treatment Options in Mental Health Treatment Plans

In our 2019 report, we examined various issues related to VHA health care providers' treatment decisions for veterans with mental health conditions.[21] In our review, we found veterans with these conditions received a range of treatments, including non-pharmacologic therapy, psychotropic medications from one or more classes, or a combination of the two.[22] We found VHA did not have guidance or monitor providers' documentation of required treatment options in mental health treatment plans, and we made two recommendations to address these issues. VHA agreed with and has implemented each of the two recommendations.

Guidance on documenting mental health treatment plans. In our 2019 report, we found that VHA did not have guidance that specified its expectation that mental health providers in specialty care document treatment plans in an easily identifiable way within veterans' medical records. According to VHA officials responsible for overseeing mental health services, specialty mental health providers should be documenting treatment plans in notes that are easily identifiable and separate from other health information. In a nongeneralizable review of medical records, we found that a majority had a mental health treatment plan recorded in a progress note. However, we viewed several examples where the treatment plan was not the only information recorded within the progress note, making it difficult to readily identify the mental health treatment plan itself.

It is important to document each veteran's treatment plan in such a manner so that the provider, or any other providers who may become involved in the veteran's treatment, can readily refer to the plan as they evaluate progress. Providers need to be able to readily access veterans' mental health treatment plans to ensure that treatment is being provided as ordered, understand why certain treatments were decided against, and assess whether treatment changes are needed.

[21]GAO-19-465.

[22]A medication may be classified by the chemical type of the active ingredient or by the way it is used to treat a particular condition. Psychotropic medication classes include, among others, (1) antidepressants, (2) antipsychotics, (3) anxiolytics, and (4) mood stabilizers. Our 2019 review found that among veterans who were diagnosed with at least one mental health condition and used VHA services in fiscal year 2018, 10 percent received psychotropic medication only, 27 percent received both psychotropic medication and non-pharmacologic therapy, 18 percent did not receive psychotropic medication or non-pharmacologic therapy, and 45 percent received non-pharmacologic therapy.

In our 2019 report, we recommended that VHA disseminate guidance for Veterans Integrated Service Networks and VA medical centers that more clearly reflects its expectation that mental health providers in specialty care should record mental health treatment plans within veterans' medical records in an easily identifiable way. VHA concurred with this recommendation and implemented it in 2020. VA provided us with a 2019 memorandum regarding mental health treatment planning. The memorandum explicitly states the requirement for mental health providers in specialty care to record mental health treatment plans as a separate, easily identifiable document in the medical record. Treatment plans are expected to ensure that it is clear what treatment is being provided, the different treatments that were considered, and any ongoing assessments used to determine whether any treatment changes are needed for the patient, according to this memorandum.[23]

Monitoring the consideration of evidence-based practices. In our 2019 report, we also found that VHA had not developed an approach for monitoring whether specialty mental health providers were documenting their consideration of different evidence-based treatment options within mental health treatment plans. The documentation of these considerations, including whether veterans are offered psychotropic medications or non-pharmacologic therapy, is required by VHA's mental health services handbook. However, in our review of a nongeneralizable sample of medical records, none of the records had documented treatment plans that showed consideration of different evidence-based treatment options for the veterans' mental health condition.

VHA officials told us at the time that VHA relied on the Joint Commission to assess specialty mental health treatment plans as part of the organization's accreditation process for each VA medical center. However, the Joint Commission's standards did not include an assessment of whether providers considered different treatment options. As a result, VHA could not ensure that specialty providers were considering all available treatment options and providing the most

[23]In April 2023, VHA issued a revision of its Uniform Mental Health Services policy to ensure every veteran receiving mental health care has an easily accessible and individualized treatment plan. VA's revised policy states that a veteran's plan should be readily identifiable in the veteran's electronic health record as a single, comprehensive, and integrated mental health treatment plan, following the veteran from one treatment setting to another rather than existing as separate plans, which could contribute to polypharmacy or other risks. Veterans Health Administration, *Uniform Mental Health Services in VHA Medical Points of Service*, VHA Directive 1160.01 (Washington, D.C.: Apr. 27, 2023.)

appropriate treatments to each veteran. It is important for specialty providers to consider mental health treatment options that are evidence-based to ensure veterans are receiving the most effective treatment. For example, the VA/DOD Clinical Practice Guideline for Management of PTSD and acute stress disorder recommends that veterans with PTSD receive individual psychotherapy over pharmacologic interventions.[24]

In our 2019 report, we recommended that VHA develop and implement an approach for monitoring treatment plans for veterans with mental health conditions to ensure that such plans include documentation that different evidence-based treatment options were considered. VHA concurred with this recommendation. In 2020, VHA implemented the recommendation, providing us with a memorandum regarding mental health treatment planning. The memorandum stated the requirement for mental health providers in specialty care to record mental health treatment plans that include, among other things, an indication that different treatments were considered. The memorandum also required VA medical centers to implement ongoing chart reviews to ensure providers meet treatment planning expectations. Specifically, the memorandum required all VA medical centers to ensure that each licensed independent specialty provider has 5 treatment plans reviewed biannually. By monitoring clearly documented treatment plans, VHA is better positioned to ensure specialty providers consider all appropriate treatment options and make modifications to that treatment as necessary in a coordinated way.

Ensuring Provider Adherence to Required Opioid Safety Risk Mitigation Strategies

In our 2018 report, we examined issues related to VA's implementation of its Opioid Safety Initiative.[25] At the time of our report, VA had seen reductions in opioid prescribing rates for veterans since implementing its initiative in 2013. For example, VA data showed the percentage of patients dispensed an opioid decreased from about 17 percent to about 10 percent from fiscal year 2013 to the first quarter of fiscal year 2018. However, in our review, we found VHA providers at selected medical facilities did not consistently follow some opioid risk mitigation strategies, and we identified a number of factors that may have contributed to this

[24]See Department of Veterans Affairs and Department of Defense, *VA/DOD Clinical Practice Guideline for Management of Posttraumatic Stress Disorder and Acute Stress Disorder* (Washington, D.C.: June 2023).

[25]GAO-18-380.

inconsistency. We made two recommendations to address these issues.[26] VA agreed with our recommendations and implemented them in 2019 and 2020.

Provider adherence to risk mitigation strategies. In our 2018 report, we found that VHA providers at selected medical facilities did not consistently follow the three key opioid risk mitigation strategies. These strategies were intended to help ensure that providers were safely prescribing opioid medications to patients at VHA medical facilities. Overall, based on our review of a non-generalizable sample of medical files for veterans at five selected facilities, we found that 75 percent of the medical files in our sample documented an annual urine screening, 26 percent indicated the veteran's names had been queried in a PDMP, and 70 percent showed informed consent from the veteran.

To help improve implementation of the opioid risk mitigation strategies, we recommended that VHA medical facilities take steps to better ensure provider adherence to the strategies. VA concurred with this recommendation and in November 2019 implemented it through a series of actions. For example, VHA created a planning tool for primary care providers related to risk mitigation strategies in electronic medical records. This tool includes the date of the last urine drug screening, the date of the last PDMP check, and the date informed consent was signed. By taking actions such as this, VHA can better ensure providers are following the opioid risk mitigation strategies and that veterans are prescribed opioids in a safe and effective manner.

Required staff to support providers in ensuring opioid safety. In our 2018 report, we also identified a number of factors that may have contributed to inconsistent provider adherence to the three key opioid risk mitigation strategies. Specifically, at the time of our review, not all VA medical facilities had access to academic detailing services, despite this VHA requirement. Academic detailing is a program in which trained clinical pharmacists are available to educate providers about evidence-based care related to the appropriate treatment of relevant medical

[26]See GAO-18-380. We made three additional recommendations in this report related to VA documenting actions it takes towards achieving the goals of the Opioid Safety Initiative, clearly defining measurable outcomes for any goals that have not been met, and tracking the use of a tool providers can use prior to initiating opioid therapy. VA concurred with these recommendations and took action between 2019 and 2021 to implement each of the three recommendations.

conditions.[27] According to VHA, academic detailing services can help ensure that providers follow opioid risk mitigation strategies. In our review, we found that most of the 18 Veterans Integrated Service Networks had established an academic detailing program; however, four had not.

We also found that four of five selected facilities did not have a pain champion at the time of our review, as required.[28] A pain champion is a part-time position that can help providers adhere to opioid risk mitigation strategies. Pain champions are generally primary care providers knowledgeable about pain care who can serve as a resource for other primary care providers by promoting safe and effective pain care. According to VHA officials, pain champions play a critical role in opioid safety and can help providers remedy gaps in pain care management for individual patients, such as incomplete opioid risk mitigation strategies.

In our 2018 report we recommended that VA ensure that all Veterans Integrated Service Networks have an academic detailing program and that all VA medical facilities have a designated primary care pain champion as required. VA concurred with our recommendation and in June 2020 implemented it. Specifically, officials from all 18 Veterans Integrated Service Networks attested that they had fully implemented an academic detailing program and that every medical facility had designated a pain champion. The availability of such resources will help provide important information to providers about evidence-based clinical practice guideline recommendations, such as non-pharmacological alternatives.

[27]At the time of our review, VHA required that all Veterans Integrated Service Networks fully implement an academic detailing program, defined as having at least three full time equivalent detailers. According to VA officials, such detailers were responsible for educating providers at all facilities as well as reviewing facility-level data on prescribing patterns and identifying potential areas of improvement.

[28]At the time of our review, VHA policy required each medical facility to maintain a 0.25-0.50 full-time equivalent pain champion serving in primary care. See VHA Memorandum, *System-wide Implementation of Academic Detailing and Pain Program Champions* (Washington, D.C.: Mar. 27, 2015).

Assessing Access to Mental Health Services for Transitioning Service Members and Veterans

In our 2024 report, we examined issues related to mental health services for transitioning service members and veterans.[29] In particular, we examined the DOD-VA Joint Executive Committee's assessment of mental health services across the transition continuum, which the committee defines as 1 year before and 1 year after separation.[30] This committee serves as the primary federal interagency body for overseeing military transition assistance activities, including coordination with providing health care for service members and veterans across the transition continuum. In our report, we found that the DOD-VA Joint Executive Committee had not assessed the effectiveness of the departments' efforts overall in facilitating access to mental health services for transitioning service members.

As described in our report, officials told us that the Committee directed the Transition Executive Committee (its subcommittee focused on transitioning from the military) to identify DOD and VA mental health-related programs and processes across the transition continuum in 2022.[31] The Transition Executive Committee identified a number of DOD and VA programs and processes, such as pre-separation counseling and health assessments, that may provide mental health touchpoints for service members during this time.[32]

However, officials responsible for the review told us that they limited their review to producing an inventory of available mental health resources,

[29]GAO-24-106189.

[30]See GAO-24-106189. In this report, we also examined the Department of Defense's inTransition program—a program that assists service members who may need support with mental health services during their separation from military service. We made four recommendations to DOD's Defense Health Agency to improve oversight of this program, including that DOD revise inTransition's enrollment criteria and outreach policy. As of November 2025, these recommendations remain open.

[31]The Transition Executive Committee provides oversight and direction related to transition assistance to service members and veterans. The National Defense Authorization Act for Fiscal Year 2024 added the Transition Executive Committee as a statutory committee of the DOD-VA Joint Executive Committee. Prior to this legislation, the Transition Executive Committee operated as a directed committee of the DOD-VA Joint Executive Committee's co-chairs. Pub. L No. 118-31, div. A, tit. XVIII, § 1805, 137 Stat. 136, 687 (2023).

[32]The Transition Executive Committee identified multiple DOD and VA programs and processes that may provide mental health touchpoints for service members prior to separation. Such programs include Transition Assistance Program pre-separation counseling, the Enterprise Individualized Self-Assessment, inTransition, pre- and post-separation VA health care registration, and the Separation Health Assessment.

and they did not assess the effectiveness of these resources. Specifically, the officials said that they did not evaluate whether or how these programs and processes collectively facilitate continuous access to mental health services across the transition continuum.

Such an assessment would provide the Committee with a more comprehensive understanding of how and when service members and veterans can access mental health services, including access to pharmacologic and non-pharmacologic treatments, across the transition continuum. As we noted in our report, this would better position the Committee to identify and address issues with any service gaps, overlap, or duplication. For example, as described in our report, we found that service members and veterans may be unaware of the various programs offering touchpoints, unable to distinguish the difference between them, and could be confused by multiple programs.

In our 2024 report, we recommended that the DOD-VA Joint Executive Committee assess the effectiveness of DOD and VA programs and processes overall in facilitating access to mental health services across the transition continuum, and then recommend any needed changes to DOD and VA. Such changes could include those to address any identified gaps or unnecessary duplication or overlap. VA concurred with our recommendation, but as of November 2025, has yet to implement it.[33] To implement our recommendation, VA stated that the DOD-VA Joint Executive Committee will ensure the proper executive subcommittees are coordinated and establish plans of action, milestones, and metrics to identify gaps or duplicative efforts. Conducting such an assessment would help VA better ensure that veterans have access to the mental health support they may need, when they need it, especially as they readjust to civilian life after serving in the military.

In closing, ensuring effective oversight of medication management for veterans is an issue of vital importance given the risks that some treatments, such as polypharmacy, can lead to dangerous outcomes for the veterans themselves. This is particularly important for those who may be vulnerable, including the growing number of veterans with mental

[33]DOD did not provide formal comments on our July 2024 report. However, in October 2024, DOD responded that it concurred with this recommendation. Its response stated that the DOD-VA Joint Executive Committee will ensure that appropriate executive subcommittees are aligned and that plans of action, milestones, and metrics are established to identify gaps or redundancies in services. DOD estimated completion of planned actions in response to this recommendation by December 2025.

health conditions and those who are transitioning from active military service to civilian life. Importantly, VA has taken a number of actions, including implementing our recommendations related to providing guidance on and monitoring mental health treatment plans for veterans. Such action will better allow VHA to oversee provider prescribing practices, including evaluating the prevalence and appropriateness of polypharmacy, to ensure that veterans receive the most efficacious treatments.

Similarly, in implementing our recommendations related to its Opioid Safety Initiative, VA has strengthened its ability to ensure provider adherence with key opioid risk mitigation strategies. In light of the risks that opioids pose, including addiction and potential overdose, it is critical that VA maintain careful oversight of providers' adherence to its risk mitigation strategies to ensure veterans are prescribed opioids in a safe and effective manner.

It remains important for VA to take action to address our recommendation to assess the overall effectiveness of DOD and VA programs and processes in facilitating access to mental health services across the transition continuum. We are encouraged that VA has stated that the DOD-VA Joint Executive Committee will establish plans of action, and we will continue to monitor steps the departments take through the committee to implement our recommendation. Addressing our recommendation will help to ensure the departments are providing critical mental health services to this particularly vulnerable population.

Chairman Moran, Ranking Member Blumenthal, and Members of the Committee, this concludes my statement. I would be pleased to respond to any questions that you may have at this time.

GAO Contact and Staff Acknowledgments

If you or your staff members have any questions concerning this testimony, please contact Alyssa M. Hundrup at hundrupa@gao.gov. Contact points for our Office of Congressional Relations and Public Affairs may be found on the last page of this statement. Individuals who made key contributions to this testimony include Amy Leone (Assistant Director), Rebecca Rust Williamson (Assistant Director), and Erika Huber (Analyst-in-Charge). Other contributors include Nan Bozzolo, Monica Perez Nelson, Ethiene Salgado-Rodriguez, and Cathy Whitmore.

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