8 July 2026

Dear Secretary Collins and Acting Under Secretary Payne,

Thank you for hosting veteran community leaders at VA Central Office on June 15, 2026, for the special briefing on informed consent. We are grateful for the opportunity to hear directly from VA leadership about your plans to address the prescribing safety concerns raised in our joint letter to Congress — signed by 35 national veterans organizations — on April 29, 2026.

We applaud your leadership in proactively addressing the concerns outlined in that letter, which urges Congress to pass the Written Informed Consent Act (HR 4837 / S 3314). This legislation requires written informed consent any time a veteran is prescribed an antidepressant, anxiolytic, stimulant, antipsychotic, or narcotic medication — with signatory acknowledgment that VA clinicians have informed veterans of possible adverse events associated with their proposed treatment, as well as available alternative treatment options. The reforms you shared with our organizations are historic in nature, and we recognize you for taking such action.

- *Implement written consent for antidepressant prescriptions for veterans under age 30*
- *Require written consent for the concurrent prescription of opioids and benzodiazepines*
- *Standardize patient education for psychotropic prescribing*
- *Enhance Electronic Health Record (EHR) documentation processes*
- *Increase compliance monitoring and oversight*

Your actions represent the first such acknowledgment, and generations of veterans applaud you for it. We believe this initial slate of reforms mark the beginning of a meaningful shift — one that will shape the VA's approach to mental health and prescribing safety, and will serve as a turning point in the national conversation surrounding veteran suicide.

As requested, we have reviewed the VA's proposed actions closely and consulted with internationally recognized psychiatric drug safety experts to identify where the current plan may be strengthened, and where reforms may fall short of fully addressing the concerns raised by the VA's own Office of Inspector General and the concerns raised to you by our organizations.

Please find our feedback and recommendations on the following pages.

Again, we thank you for your leadership in addressing this crisis. We deeply appreciate the invitation to provide feedback on these proposed changes and are honored to support you in making prescribing practices safer and smarter for our nation's veterans.

Respectfully,

Air Force Sergeants Association	American GI Forum
The American Legion	American Veterans (AMVETS)

Association of the United States Navy (AUSN)

Black Veterans Project

BurnPits 360

Commissioned Officers Association of the United States Public Health Service USPHS

Common Defense

Enlisted Association of the National Guard of the United States (EANGUS)

Fleet Reserve Association (FRA)

Grunt Style Foundation (GSF)

Jewish War Veterans of the USA (JWV)

Korean War Veterans Association

Marine Corps League

Military Veterans Advocacy, Inc

National Association of County Veteran Service Officers (NACVSO)

National Defense Committee (NDC)

Non Commissioned Officers Association (NCOA)

Operation First Response

Pink Berets

Save A Warrior (SAW)

Student Veterans of America (SVA)

The Retired Enlisted Association (TREA)

Tragedy Assistance Program for Survivors (TAPS)

US Army Ranger Association (USARA)

Veterans of Foreign Wars (VFW)

Veterans Strategic Solutions

Vietnam Veterans of America (VVA)

With Honor

Wounded Paw Project

Feedback and Recommendations

VA Mental Health Medication Safety Advisory Committee – The Need for Veteran and Independent Expert Inclusion in Reform Development and Implementation

A common theme emerged as our organizations reviewed the Written Informed Consent and Informed Consent reforms the VA will be implementing: the voices of veterans and outside experts were not included in the conversations that produced this initial slate of reforms.

These discussions are occurring as result of an unprecedented coalition of national veterans organizations calling on Congress for prescribing safety reforms, and VA leadership taking the initiative to act ahead of congressional action. Despite this, our organizations were not consulted by VA mental health leaders following the issuance of our joint letter on April 29th — even as those same leaders were advising VA leadership on how to respond.

Equally notable, the internationally recognized experts who have produced the definitive body of work on prescribing safety and safe deprescribing practices were not engaged. As an example, Dr. Mark Horowitz–author of the Maudsley De-Prescribing Guidelines for Antidepressants, Benzodiazepines and Z (sleep) Drugs–was invited to join a meeting with Under Secretary Bartrum and Deputy Under Secretary Payne on 30 June, 2026. Otherwise VA mental health leaders had never engaged or requested his counsel, though previous introductions had been made and recommended.

A straightforward reality must be acknowledged: the same group of individuals who have overseen psychotropic drug safety and prescribing policy within the VHA for the past two decades did not raise these concerns to VA leadership, nor did they proactively act to address them. It has taken a coalition of national veterans organizations, unprecedented action by the HHS Secretary, and outside advocates to bring these issues forward.

Recommendation: It is our recommendation that the President or the Secretary should utilize the Federal Advisory Committee Act to establish a standing advisory committee composed of veterans and independent outside experts, charged with advising VHA leadership and mental health leaders on the development of new psychotropic safety policies. This committee should remain engaged throughout the implementation of these reforms and provide ongoing counsel. We recommend the committee consist of eight members: four representatives from veteran-serving organizations, and four independent experts with no current affiliation with the Department of Veterans Affairs.

Written Consent for Antidepressants Should Extend Beyond Age 30

The VA's decision to require written informed consent for antidepressant prescriptions for veterans up to age 30 represents a meaningful step — one that extends beyond the FDA's Black Box Warning, which targets young adults up to age 24.

As VHA leaders acknowledge the suicide risk associated with antidepressants does not end at 24 years-old, it should also acknowledge this risk does not end at 30 either. The broader body of research supports this: antidepressant-associated suicide risk has been documented across all adult age populations, not only among young people. While some studies suggests possible protective factors against suicidal ideation among adults 65 and older, this finding addresses only suicide risk — it does not account for the range of other serious, potentially permanent harms associated with this drug class.

Those harms include dependency and withdrawal syndromes; Post-SSRI Sexual Dysfunction (PSSD), which can produce persistent sexual dysfunction, emotional blunting, and cognitive impairment long after discontinuation; cardiovascular effects; and increased risk of adverse outcomes when combined with other commonly prescribed medications.

Recommendation: Written informed consent for antidepressant prescriptions should apply to all veterans across all age groups receiving care through the Veterans Health Administration.

Written Consent for Concurrent Prescribing of Benzodiazepines and Opioids

The VA's decision to require written consent for the concurrent prescribing of benzodiazepines and opioids is warranted and overdue. This drug combination has long been recognized by VA clinicians and public health experts alike as contraindicated and associated with serious adverse outcomes, including respiratory depression and death. We applaud this action, as do we support the VA’s existing policy requiring Written Consent for the prescribing of opiates for long-term pain management.

At the same time, psychiatric drug safety experts identified an inconsistency in the VA's approach regarding benzodiazepines: written informed consent will be required for antidepressants prescribed to veterans up to age 30, yet benzodiazepines — prescribed as standalone medications — will not carry the same requirement. This is difficult to reconcile given the extensive body of evidence of harm associated with this drug class.

The risks of benzodiazepines, particularly their inappropriate long-term use, have been documented in public health literature and the subject of congressional hearings since the 1970s. The VA itself has operated a VHA-wide initiative since 2012 to taper veterans diagnosed with PTSD off benzodiazepines, after internal research confirmed this class of medication to be contraindicated for that population. Those efforts successfully reduced benzodiazepine

prescribing rates for veterans with PTSD from more than 27% in 2012 to less than 7% today. Despite this progress, inappropriate prescribing of benzodiazepines continues — even though clinical guidelines indicate they should never be prescribed for more than two weeks and should be used only as needed. Concerns are significant enough that the United Kingdom has enacted strict regulatory restrictions on prescribing this drug class, and numerous other countries prohibit their prescription or possession entirely.

Recommendation: Written informed consent should be required for all standalone benzodiazepine prescriptions, not only those prescribed in combination with opioids. The requirement should not be limited to any specific age group. The existing Written Consent policy for the prescribing of opiates for long-term pain management should also be continued.

Written Consent for Antipsychotics

Antipsychotic medications carry some of the most serious documented risk profiles of any drug class regularly prescribed within the VA system, yet they are frequently prescribed to veterans off-label — most commonly for PTSD and sleep disorders — outside the indications for which they were approved.

The risks associated with antipsychotics are severe and, in some cases, irreversible. Tardive dyskinesia, a potentially permanent movement disorder, can develop after prolonged use and can persist long after the medication is discontinued. Antipsychotics are also associated with significant metabolic effects, including substantial weight gain, insulin resistance, and elevated risk of type 2 diabetes. Cardiovascular risks — including arrhythmia and sudden cardiac death — have been documented across this drug class. In elderly patients, the FDA has issued a Black Box Warning indicating increased mortality risk. Neuroleptic malignant syndrome, though rare, is a potentially fatal adverse reaction.

Veterans are often not informed of these risks at the time of prescribing, particularly when these medications are prescribed off-label as sleep aids or mood stabilizers rather than as treatments for psychotic disorders.

Recommendation: Written informed consent should be required for all antipsychotic prescriptions across the Veterans Health Administration, regardless of the indication for which they are prescribed. Consent documentation should explicitly address the risk of permanent or long-term adverse effects, including tardive dyskinesia and metabolic harm, and should inform veterans when a medication is being prescribed for an off-label purpose.

Written Consent for Stimulants

Stimulant medications — prescribed within the VA most commonly for attention-deficit/hyperactivity disorder (ADHD), traumatic brain injury (TBI)-related cognitive

symptoms, and fatigue — carry meaningful cardiovascular, psychiatric, and dependency-related risks that veterans are often not fully informed of prior to initiating treatment.

Cardiovascular risks associated with stimulants include elevated heart rate and blood pressure, and in some cases increased risk of arrhythmia, heart attack, or stroke — particularly in veterans who already carry elevated cardiovascular risk due to age, service-related conditions, or comorbid diagnoses. Psychiatric adverse effects can include stimulant-induced anxiety, agitation, paranoia, and in some cases psychosis or mania. Stimulants carry a recognized potential for misuse and dependency, and abrupt discontinuation can produce significant withdrawal effects.

Veterans with TBI or complex psychiatric histories represent a population for whom the risk-benefit calculation of stimulant prescribing warrants particularly careful, documented discussion — yet this is precisely the population in which stimulant prescribing has grown most significantly within the VA.

Recommendation: Written informed consent should be required for all stimulant prescriptions across the Veterans Health Administration. Consent documentation should address cardiovascular risks, psychiatric adverse effects, dependency potential, and the implications of long-term use. Veterans should be informed of behavioral and non-pharmacological alternatives where they exist.

Written Consent for Narcotics

The opioid epidemic has touched every corner of American life, and the VA's opioid prescribing history is well documented. Despite this history and the known risks of narcotic medications, written informed consent is not universally required across the VA system at the time a veteran is first prescribed an opioid.

Narcotics carry serious risks that veterans deserve to understand before initiating treatment: dependency and opioid use disorder, respiratory depression and overdose risk, cognitive impairment, hormonal disruption with long-term use, and profound withdrawal effects upon discontinuation. These risks are compounded in veterans who are concurrently prescribed benzodiazepines, muscle relaxants, or other central nervous system depressants — combinations that remain more common within the VA system than clinical guidelines recommend.

Veterans also deserve to be informed of non-opioid pain management alternatives at the point of prescribing, including evidence-based complementary and integrative approaches that the VA has invested in but which are not consistently offered or explained as alternatives prior to initiating opioid therapy.

Recommendation: Written informed consent should be required for all narcotic prescriptions across the Veterans Health Administration, including initial prescriptions and any significant

changes in dosage or duration. Consent documentation should clearly address dependency risk, overdose risk, risks associated with concurrent use of other central nervous system depressants, and available non-opioid alternatives. This requirement should be universal and not contingent on veteran age or diagnosis.

Conclusion

The recommendations outlined above were developed to be germain to the topic of Informed Consent and Written Informed Consent policies and directives at the Veterans Health Administration. In this discussion, we excluded topics ranging from, but not limited to: provider and mental health clinician retraining on psychotropic safety; reformed and updated deprescribing protocols for psychotropics; caregiver and family inclusion within the Informed Consent process; implementation of pharmacogenomic testing prior to the prescribing of medications; differential diagnosis, and full patient workups and evaluations prior to diagnosing/prescribing; psychotropic prescribing, mortality and adverse outcome data releases for public review; or the removal of suicide as the VA's "top clinical priority," and instead making veteran suicide the "top priority" VA-wide.

We look forward to continuing to support the VA in its mission to provide the best in class, safe and effective care our warfighters and veterans deserve, and stand ready to assist at any time.