STATEMENT
OF
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On behalf of

The Hawaii Society of Addiction Medicine

Senate Committee on Veterans' Affairs
United States Senate
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Mr. Chairman and distinguished members of the Committee, thank you for the opportunity to come before you today to offer these comments regarding the treatment of Hawaii's veterans who have drug related problems.

I am Dr. Kevin Kunz, from the Hawaii Society of Addiction Medicine. We are an organization of 26 Hawaii physicians, and a chapter of the American Society of Addiction Medicine. Our organization is dedicated to improving the treatment of alcoholism and other addictions, educating physicians and medical students, promoting research and prevention, and enlightening and informing the medical community and the public about these issues.

Our member physicians work in research, administration and the direct clinical care of persons with addictive disease. We can be found in many practice settings, including solo practices, hospitals, community clinics, rehabilitation programs, and within government agencies, including the VA.

We wish immediately to acknowledge our military men and women from both past and present wars, and all veterans. Their volunteerism and gallantry is a source of pride for all Americans, and we sincerely thank them for their service. And particularly, we wish our men and women in the current battlefields a speedy and safe return home.

My comments today will be influenced by my own 25 years of family practice medicine in Kona, – where many veterans are my patients, and where I have a working relationship with the superb staff of the VA's Community Based Outpatient Clinic and the Vet Center. I have been sub-specializing in addiction medicine for 11 years, and in this capacity, have cared for many more Big Island veterans. I am also a Viet Nam veteran and have personally received care in Hawaii's VA programs.

The association of combat service, post-traumatic stress disorder and substance abuse is well know. Perhaps the most poignant lessons from that old war, Viet Nam, have been these: 1) PTSD and its' co-morbidities are predictable, preventable and treatable. 2) The

co-occurrence of PTSD and substance abuse problems is the norm, not the exception. 3) PTSD can be successfully treated only to the extent that co-existing substance abuse is treated. Senators, the problems of PTSD, addiction and dysfunctional lives will only grow as more Vets return.

And the final lesson: whether or not we honor the war, we must always honor and care for the Warrior. We must have adequate addiction care resources within the VA system to treat our veterans in need.

I will now list 8 specific problems and make recommendations for areas within Hawaii's VA programs, with particular attention to the outer islands, where resources for the treatment of substance abusing veterans are woefully inadequate.

1. Substance Abuse Counselors in CBOCs
   On the outer islands, the VA Community Based Outpatient Clinics (CBOC) are all lacking Certified Substance Abuse Counselors (CSACs). A VA counselor or therapist caring for a Vet with PTSD will of course ask about and advise (often with a referral to AA or NA) about substance use, but if the Vet has a significant alcohol of drug problem, he or she will also need to obtain specialized services, perhaps medical detoxification. Or counseling, often delivered in a group setting with educational and cognitive-behavioral therapies. Ten years ago, there was a CSAC rotating between Hilo and Kona. Now we have none, and the need is as great, if not greater. We recommend that the CBOCs on Maui, Kauai and the Big Island (Kona and Hilo) all receive a CSAC position. And of course, the staff person would also need the physical space to carry out their job.

2. Modern Treatment for Opiate Addiction
   Many veterans, from previous wars and from Afghanistan and Iraq, have come home with, or subsequently acquired, opiate problems. Opium, heroin and pain pills are all readily available in many battlefield and civilian settings. In addition to the war addicted, America now has, currently, an epidemic of prescription opiate abuse and dependence, and non-opium, non-heroin opiate prescription drugs are readily available. And it is notable that Afghanistan produced more opium last year than any country in recorded world history. Our military men and women there are at an increased risk, and there are now reports of Americans returning home addicted to Afghanistan's opium. Opiates can be a tonic for the pain and dysfunction of war, and of PTSD, and then they often become an insurmountable addiction. When the problem of heroin addiction in returning Viet Nam Vets was recognized, President Nixon appointed America's first Drug Czar, who quickly stimulated the research that located the brain's own heroin, the endorphins and enkephalins, and the brain's opiate receptors. Next were the treatment initiatives, which included residential and outpatient programs, and the medication methadone. The VA system played a large role in these treatment initiatives.

If medication is used for the detoxification or maintenance therapy of opiate addiction, methadone is no longer the only option, and probably is not best option. Five years ago Congress passed the Drug Abuse Treatment Act of 2000, which made available the medication buprenorphine for the treatment of opiate dependence. Unlike methadone, buprenorphine can be prescribed by physicians outside of federally regulated, often dysfunctional, methadone clinics. It has less risk of diversion and abuse, and has a much better safety profile than methadone. Recently, methadone has become a leading ingredient in overdose deaths – in part because of increased availability for the treatment of pain, and diversion to illicit use. Although thousands of physicians are successfully prescribing buprenorphine for opiate dependent patients, the VA has been slow to integrate this medication. Our colleagues from across the country say that Vets are not being offered this option with the VA system. In Hawaii, it is not available from the VA. We recommend that this proven, safe and accepted therapy become available within Hawaii's VA programs for the treatment of opiate withdrawal, and opiate maintenance therapy in properly selected opiate dependent veterans.

3. Residential, and Other Treatment Opportunities

The outer islands do not have residential or "clean and sober" houses available for Vets who require these levels of substance abuse care, and do not contract with existing residential or programs. This may be due to the complicated and restrictive federal requirements for such facilities. We recommend that some accommodation be made to permit matriculation of Vets in local residential programs and "clean and sober" houses, as well as outpatient substance abuse treatment programs. Perhaps the VA can establish contract services with existing programs and practitioners until they have their own outer-island operations in place. We believe that there are counselors, psychiatrists and addictionists who have had experience in veterans' care who could fill some of the gaps. This also would address the "community cooperative" aspects of the VA's care of Vets, which I will comment on again.

4. Hilo PTSD Rehabilitation Program/Hilo Veterans Mental Health Services

The relocation of the PTSD Rehabilitation Program (PRRP) from Hilo to Oahu has left a gap in services here. The benefit of this program on the Big Island was not limited to the Vets who participated there. The staff was available to other health care providers on the Big Island for consultation, and the recovering Vets themselves were very effective outreach workers and therapeutic guides for other Vets with PTSD and/or alcohol or drug co-morbidities. There is the anticipated development of new Mental Health services in Hilo. The announcement, two days ago, of additional funding for PTSD treatment, including the much needed additional staffing for the Hilo CBOC provides the opportunity for this proposal to become reality. Expanded mental health services beyond what is currently provided by the neighbor island CBOCs and Vet Centers are needed. It is to be hoped that Hilo will lead the way in establishing a model of comprehensive treatment that can be instituted on the other neighbor islands

5. Prevention Services.
   Although some veterans from the current war are trickling into the CBOCs and Vet Centers, we expect that it will be 5-10 years, or longer, before most Vets with PTSD and related substance use problems ask for help. Yes, some of them will be seen in Emergency Rooms, jails and institutions, divorce courts and unemployment lines before then. Often now, it is the family of the Vet who says that something is wrong, but they can't get the Vet to seek help. Our military services are pre-emptively dealing with this – by educating personnel about the risk of PTSD, and the availability of counseling. But history has shown that most Vets don't see the problem, or resist help. Therefore, there needs to be more outreach early on, both to the newly discharged Vet, and to family members. Just consider the 3-400 National Guard soldiers who are expected to return to the Big Island this year. We recommend that a new set of outreach activities for Vets and families of Vets be instituted.

6. Training VA Addiction Physicians
   The education and availability of physicians who treat addictive disease is an important issue. Specialists in addiction medicine have several routes to certification. Residency programs that train doctors are one of the best. There is a combined addiction medicine/psychiatry residency available in Hawaii. We are lucky to have it – it is an invaluable resource, well run with a positive impact on Hawaii's physicians-in-training and for all of our medical community. This residency is run through the University of Hawaii's School of Medicine. The Spark Matsunaga VA Medical Center is lacking a Post-Graduate Year – 5 position for an addiction medicine/psychiatry resident. Such a physician could rotate interisland and educate and support physicians – VA and private practice – in the care of Vets. This position would support and compliment any other expansion of needed services statewide, and allow better integration of chemical dependency care for Hawaii's veterans. We recommend that this physician training position be funded.

7. Community Cooperation
   VA physicians, including psychiatrists, often do not participate as equal members of the local medical community. At least on the outer islands, they do not routinely share hospital work, including call, with other physicians. There are two downsides to this. First, it sets up the veterans and VA physicians as being apart from, rather than a part of, the community health care resource network. Second, when a Vet who is receiving care from the VA needs hospital admission, he or she is "dumped" on the community physician who is on call. This alienates the on-call physicians, and speaks poorly to the continuity of care that all patients deserve. We recommend, at a minimum, that VA physicians maintain

membership in the local medical societies, and that they maintain at least "courtesy staff" status at local hospitals.

8. Crisis in Veterans Health Care

   Is it not a crisis, and is it not shameful that for many of the services that I have listed, a veteran must become so ill and dysfunctional, that finally their care is provided by our welfare system, and our jails and other institutions rather than the VA? And what does the future look like?

   The number of VA patients with PTSD increased 42% from 1998 to 2003. The number of veterans receiving compensation for PTSD has grown almost 7 times as fast as the number receiving non-PTSD disability. These increases reflect mostly Viet Nam veterans seeking help decades after their service. Even with adequate outreach, it may be, as mentioned, 5, 10 or more years before Vets from the current wars actually show up at treatment centers. We know that 26% of veterans returning from Iraq and Afghanistan who were treated at VA medical centers in 2004 were diagnosed with mental health disorders. And that up to 20% of all Operation Iraqi Freedom and Operation Enduring Freedom veterans are believed to meet criteria for PTSD.

   Despite a welcome 8% increase that Congress mandated for VA Mental Health Care in 2006, there remains a general perception among Vets, and many VA staff, that the VA is trying to cut back services. There is perceived erosion, of lack of care. If this is true, it is certainly sad.

   Here we are funding wars in two countries, increasing the probability that there will be more men and women with war injuries, including PTSD, alcoholism and drug addiction, and we are cutting services? Will we wait a few decades, then fight the war at home – again - the war on drugs, the war on PTSD, the war on the broken lives of gallant veterans and their blameless children? We recommend that America's commitment to our present wars abroad be matched with resources to care for our Warriors when they come home. Now, and in the future.

   Thank you for the opportunity to have offered these comments.