S. HRG. 109–376

FIELD HEARING ON THE STATE OF VA CARE IN HAWAII: PART III

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

SECOND SESSION

JANUARY 13, 2006

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JANUARY 13, 2006

SENATORS

WITNESSES

APPENDIX

FIELD HEARING ON THE STATE OF VA CARE IN HAWAII: PART III

FRIDAY, JANUARY 13, 2006

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:10 a.m., in Conference Room at the Department of Labor and Industrial Relations Building, 1990 Kinoole Street, Hilo, Hawaii, Hon. Daniel Akaka (Ranking Member) presiding.

Present: Senator Akaka.

OPENING STATEMENT OF HON. DANIEL K. AKAKA, U.S. SENATOR FROM HAWAII

[Typed from Senator Akaka's prepared statement; the Senator's opening statement was not taped.]

Senator AKAKA. Aloha. Welcome to the fourth and final Senate Committee on Veterans' Affairs field hearing in Hawaii. It is a pleasure for me to leave our Nation's capital and conduct official Senate business here in my home State. We have had three successful and informative hearings this week, and I'm sure this hearing will be no different.

At this time I would like to thank the staff at the Hilo and Kona Vet Centers and Clinics. All of you do a wonderful service for our veterans.

The focus of this hearing will be on readjustment care for returning servicemembers. We are all aware that after Vietnam and other wars, some of our servicemembers who honorably served our Nation were not provided with the care and services they needed to reintegrate into society. Caring for returning servicemembers is part of the continuing cost of war.

We must act now to assure adequate levels of care and services are available for those that may leave the Armed Forces after returning from overseas. The earlier a veteran receives care after separation from the military, the greater the likelihood the veteran will not have long-term problems.

With this thinking in mind, I sponsored the Vet Center Enhancement Act, which recently passed the U.S. Senate. This legislation authorizes the Department of Veterans Affairs to hire more Global War on Terror outreach coordinators, gives VA authority to administer bereavement counseling at Vet Centers, and authorizes $180 million for Vet Centers. This legislation goes a long way to providing the care and services Hawaii's returning servicemembers desperately need. But we should not stop here.

Today we will investigate what is working and what needs to be done better. We have wonderful witnesses today. Our first panel consists of high-ranking military and VA personnel. Lieutenant General Pete Osman is the Deputy Commandant for Manpower and Reserve, United States Marine Corps. Major General Benjamin R. Mixon is the Commanding General of the 25th Infantry Division. Major General Robert Lee is Adjutant General for the State of Hawaii. Colonel Matt Horn is the Deputy Commander, U.S. Army Reserve, Commander, 9th Regional Support Command.

Lastly, Panel I has the Honorable Dr. Jonathan Perlin, Under Secretary for Health at VA. He is accompanied by Dr. Robert Wiebe, VA Director for the Sierra Pacific Network; Dr. James Hastings, Director of the VA Pacific Islands Health Care System; and Dr. Steven A. MacBride, Chief of Staff for the VA Pacific Islands Health Care System.

The second and final panel is made up of John Harlan, Team Leader at the Hilo Vet Center; Dr. Kevin Kunz, President of the American Society of Addiction Medicine; Sergeant Greg Lum Ho of the Army National Guard; and a veteran, Katherine King. I want to thank you all for attending this hearing, and I look forward to your comments.

Finally, I want to address the fact that there are many veterans who are here today and who want to testify. We want to hear from you. Unfortunately, we cannot accommodate everyone's request to testify. However, we are accepting written testimony for the record. You can rest assured that we will read your written testimony. If you have brought written testimony with you, please give it to the Committee staff who are located at the back of the room.

If you do not have written testimony, but would like to submit something, my staff is in the back of the room to assist you. In addition, the Committee staff is joined by VA staff who can respond to the questions, concerns, and comments that you raise.

Once again, mahalo to all who are in attendance today, and I look forward to hearing from today's witnesses.

[The prepared statement of Senator Akaka follows:]

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STATEMENT OF LIEUTENANT GENERAL H.P. (PETE) OSMAN, U.S. MARINE CORPS, DEPUTY COMMANDANT FOR MANPOWER AND RESERVE

[Typed from General Osman's prepared statement; the General's testimony was not taped.]

General OSMAN. Mr. Chairman, Senator Akaka, and distinguished Members of the Committee, I am grateful for this opportunity to appear before you today to discuss the interaction between the Marine Corps, DoD, and the Department of Veterans Affairs to care and support our returning servicemembers, including those from the State of Hawaii.

The State of Hawaii has been the source of great help to the Marine Corps in the Global War on Terrorism. Marine Corps Base Hawaii, including the Kaneohe Bay and Camp H.M. Smith installations, is home to over 16,000 Marines, sailors, family members, and Marine Corps civilian employees. Tripler Army Medical Center in Honolulu is also an important facility for the Marine Corps, currently providing medical care to several injured Marines. The Spark M. Matsunaga VA Medical Center and the Oahu VA healthcare clinic are also resources for our injured servicemembers.

The State of Hawaii has also witnessed its share of casualties and injuries during the Global War on Terrorism, with two Marines with Hawaii homes of record killed in combat and nine others injured. The Marine Corps is highly focused on caring for these and all injured Marines, ensuring that their family members are provided for and comforted in the wake of their injury, and, when necessary, assisting with their transition to civilian life.

Supporting injured Marines and their families is a complex task. We do our best to tailor our support to fit their individual needs. This support comes from numerous Marine Corps initiatives designed to promote and provide treatment for the mental and physical well-being of all servicemembers and their families. These include community-based services, buddy care, non-medical support resources, chaplains, morale, recreation, and welfare programs, and the full spectrum of clinical care and patient movement of the military health system.

There are also many joint VA/DoD programs whose goal is to help injured servicemembers transition from DoD to VA healthcare, convert from DoD to VA benefits systems, improve VA/DoD sharing of personnel and healthcare information, and to otherwise assist servicemembers who, for whatever reason, are transitioning to civilian life.

Today, I'd like to touch upon several programs, many of which are the result of lessons learned from the Marine Corps' central role in Operation Iraqi Freedom and Operation Enduring Freedom. Many of these programs involve close communication and joint effort with VA. All of these programs are available to all Marines, including those stationed here in Hawaii; many have program liaisons based at Marine Corps Base Hawaii.

Military leaders and medical professionals realize that many deployed servicemembers experience combat stress and that it affects some individuals more than others. The stress of current operations has affected not only those Marines deployed to a war zone, but also those remaining in garrison and their family members.

To maintain the readiness of the Marine Corps as a war-fighting force, we remain vigilant in watching our young, expeditionary, and vigorous members for signs of distress and to effectively manage operational stress at every level. The goal of this effort is to provide pre-deployment training, assistance when the stress is occurring, and post-combat monitoring and assistance to identify mental health problems early, so they will have the best chance of healing completely.

Since the Marine Corps crossed the line of departure into Iraq in March 2003, we have continuously developed and improved our operational stress control programs based upon lessons learned. For example, in January 2004, we launched the Operational Stress Control and Readiness (OSCAR) program, which embed mental health professionals with ground units. OSCAR has been successful in helping Marines deal with the acute stress of combat. It also keeps Marines with low-level problems at their assigned duties and allows those with more severe conditions to immediately receive appropriate treatment.

In addition, we learned that as we redeployed from OEF and OIF, that returning home from an operational deployment can be a stressor, not only for Marines, but for their family members. In response, in May 2003, we launched the Warrior Transition and Return and Reunion programs. These programs help Marines and their families cope with the stress of homecoming.

Though we provide many prevention and treatment programs, we know that their success is dependent upon Marines confidently availing themselves of the support offered. As such, we consistently

reassure Marines that the combat/operational stress they are experiencing is not uncommon, and we urge use of available resources. We also emphasize that stress heals more quickly and completely if it is identified early and managed properly. With this in mind, over the past 2 years we have greatly expanded our efforts to educate Marines and their family members about combat/operational stress control.

To coordinate our efforts, we have established a Combat and Operational Stress Control (COSC) section in our Manpower and Reserve Affairs Department. The objectives of the Marine Corps' COSC program are to provide the tools to prevent, identify, and treat combat/operational stress injuries in war fighters and their family members before, during, and after deployment.

To assist during the pre-deployment phase, Marine officers and staff NCOs are trained to prevent, identify, and manage stress injuries. Moreover, Marines are trained that stress is to be expected and how to monitor and manage personal stress levels. During deployment, in addition to OSCAR, there are mentorship programs and treatment services by chaplains.

For our dedicated families who await the return of their Marine, we have counseling and referral services available through various venues. For example, the Key Volunteer Network supports the spouses of the unit Marines by providing official communications from the command about the welfare of the unit and other key status or information.

We also have Marine Corps Community Services programs, and Military/MCCS One Source. Military/MCCS One Source is a 24/7/365 information and referral tool for Marines and their families that provides counseling on virtually any issue they may face, from childcare to deployment stress to financial counseling.

Additionally, in the case of mass casualties experienced by a command or unit, the Marine Corps' Critical Incident Stress management trained teams provide crisis management briefings to family members and friends of the command or unit. During crisis management briefings, Marine Corps personnel, chaplains, and Managed Health Network (MHN) counselors are available to provide information and answer questions concerning the casualties.

MHN is an OSD-contracted support surge operation mechanism that allows us to provide augmentation counselors for our base counseling centers and primary support at sites around the country to address catastrophic requirements.

After deployment, we help with readjustment by providing briefs for Marines and families on how to recognize problems and seek help, and by screening redeployed Marines for mental health problems. Marine officers and NCOs receive training close to the time of redeployment on the normal stress of readjusting to life in garrison and of reuniting with family members. They also are taught how to identify their Marines who are having problems, and how to get them help.

We have begun screening all returned Marines and sailors for a wide variety of health problems after they have been back home for 90 to 180 days, and those who screen positive are evaluated and treated. Family members also receive redeployment stress briefs, including information about how to take care of their own stress

as they reunite with their Marine spouses, and how to know whether their spouse is experiencing a stress problem that requires attention.

To ensure COSC training participation, we have a system using the Marine Corps Total Force System for unit-level tracking by individual Marines during pre-deployment, re-deployment, and post-deployment. We have also implemented the Department of Defense pre-deployment and post-deployment health assessments, which facilitates early identification and treatment of persistent stress problems.

Another important component of COSC is our web-based information and referral too, the "Leaders Guide to Managing Marines in Distress." The guide gives leaders the ability to help Marines at the point of greatest impact, Marine to Marine. It offers leaders, at all levels, information to resolve high-risk problems faced by Marines that could be detrimental to personal and unit readiness.

The faster and more effectively these problems are solved, the more time the individual and unit will have to focus on the mission. The guide is separated into 6 major categories: deployment, family, personal, harassment, substance use, and emotional. Within these categories, there are 16 main problem areas that include an overview of the problem, risk factors, why Marines may not seek help, prevention strategies, resources, and Marine Corps guidance. The guide can be accessed at *http://www.usmc-mccs.org/leadersguide*.

The Marine Corps appreciates the Committee's attention to this important issue, and I commend your steadfastness in ensuring that servicemembers receive appropriate care in terms of both prevention of combat stress and treatment. I can assure you of the Marine Corps' commitment to the mental and emotional well-being of our force remains strong. We will continue to seek validation of our COSC program and closely interact with commands to capture lessons learned and best practices for future improvements and adjustments.

Care for Injured Marines: The Marine Corps has a long history of caring for its fallen and injured Marines. Many of the Marines and sailors who have suffered extremely serious combat injuries would not have survived in previous wars. Due to improved combat equipment, forward-deployed trauma stations, and post-injury medical care, they are fortunately still with us.

Nevertheless, their trauma still has a potentially devastating impact on them, their families, and their future. Therefore, the Marine Corps places top priority on the health care of our returning injured Marines.

Marine Casualty Services: Marines who are seriously wounded in Iraq or Afghanistan, once stabilized, are ordinarily transported first to National Naval Medical Center (NNMC) in Bethesda, Maryland. Based on lessons learned from the treatment and processing of servicemembers injured during OIF/OEF, we established a Marine Casualty Services (MCS) patient administration team at that facility under the leadership of a Marine officer.

MCS at Bethesda is a team of 27 professionals dedicated to assisting every admitted Marine. The team is composed of surgeons, mental health specialists, nurses, case management specialists,

and a VA benefits coordinator. The team helps with all facets of the servicemembers' care—from assisting with family members' travel and lodging, to filing all appropriate claims for entitlements, to ensuring medical records are transferred in a timely fashion.

They collaborate with the hospital staff, family members, and VA Medical Center staff on a daily basis to ensure a seamless transition of care and services. Intensive case management is a key component for post-discharge and follow-up care. Continued communication and coordination between the Marine Corps medical treatment facility case manager, Veterans Health Administration/DoD liaison, VA Medical Center OIF/OEF case manager, and the Marine for Life—Injured Support representative, is absolutely crucial as our injured Marines proceed through their recovery.

To enhance continuity, clinical outcomes, and improve family support, the trauma team doctors at NNMC conduct weekly teleconferences with primary VA transfer sites. Because of the importance of the MCS, the Marine Corps has established teams at Andrews Air Force Base to meet all incoming medevac flights, a team at Walter Reed to provide onsite support for Marines receiving amputee rehabilitation, and personnel augmentation to the Joint Personnel Effects Division at Aberdeen. These teams remain actively involved with the day-to-day care of our injured Marines and do their best to support and advocate for our Marines and families even after they transfer to a VA Medical Center or other facility.

Marine for Life—Injured Support is a formal program instituted by our Commandant to assist injured servicemembers and their families. The concept of Injured Support gives renewed meaning to "Once a Marine, Always a Marine," and assures all Marines that they never truly leave the Corps.

The goal of this program is to bridge the difficult gap between military medical care and transition to VA. The key is to ensure continuity of support through transition and, in combination with Office of the Secretary of Defense Military Severely Injured Center, to provide case management tracking for several years forward.

As our injured Marines continue with their recovery, potentially transfer from active to veteran status, and assimilate back into their communities, Marine for Life—Injured Support will be their greatest supporter and advocate. This program has been in operation since last January with features that include advocacy within both DoD and external agencies, assistance with military disability processing and physical evaluation boards, assistance with employment, and improved VA handling of healthcare and benefit cases.

On average, 30 percent of our discharged injured Marines who have been contacted request and receive assistance. Injured Support representatives interact with Marine Casualty Services on a weekly basis to provide program information and contact numbers to hospitalized Marines and family members. Marine for Life—Injured Support is living proof of our motto—"Semper Fidelis."

Health Insurance Portability and Accountability Act (HIPAA): While the Marine Corps is not a keeper of servicemembers medical records, it wants to make sure that MCS and Marine for Life—Injured Support follow the law's mandates. As such, these personnel have received training from the NNMC HIPAA compliance specialist, as well as online follow-up training. Moreover, all injured

Marines receiving healthcare at DOD and VA installations are counseled on their HIPAA rights and provided the necessary disclosure forms. In June 2005, DoD and VA signed a MOU on the sharing of information, called the HIPAA MOU.

Transition Assistance: Our hope is that many of our injured Marines will be able to return to duty. Clearly, in many cases, this is not possible. Consequently, the Marine Corps and DoD, along with the help of VA, has developed several initiatives to assist servicemembers who, for whatever reason, transition back to civilian life.

Seamless Transition Program: The Marine Corps is an active participant in the DoD/VA Joint Seamless Transition program. VA established the program in coordination with the services to facilitate and coordinate a more timely receipt of benefits for injured servicemembers while they are still on active duty.

There are VA social workers and benefit counselors assigned at eight Military Treatment Facilities (MTFs) that serve the highest volume of severely injured servicemembers, including Walter Reed Army Medical Center and National Naval Medical Center in Bethesda. VA staff stationed at these MTFs brief servicemembers about the full range of VA benefits, including disability compensation claims and healthcare.

They coordinate the transfer of care to VA Medical Centers near their homes, maintain follow-up with patients to verify success of the discharge plan, and ensure continuity of therapy and medications. These VA case managers also refer patients to VA benefits and vocational rehabilitation counselors. As of August 2005, more than 3,900 patients have received VA referrals at the participating military hospitals.

In order to enhance the important value of the Seamless Transition program, the Marine Corps recently assigned two field grade officers to the VA Seamless Transition Office. This has facilitated better integration of Marine Corps and VA handling of servicemembers cases, involving both VA healthcare and benefits delivery. These liaisons, with the help of other Marine for Life—Injured Support counselors and VA liaisons, also help ensure that all documents needed by VA are gathered to begin VA processing.

Many of the seriously injured Marines will already be under the VA umbrella for care and treatment by the time their case is finalized at the physical evaluation board. With the Marine liaisons officers at the VA Seamless Transition Office, injured servicemembers are now provided better case management oversight through the transition process to VA.

In many instances, the Marine Corps has expedited a Marine's separation, making his or her eligible to receive compensation from VA in 30 days instead of the 60-plus days that was previously experienced. This Marine Corps effort has assisted not only Marines, but members of the other services, too.

Transition Assistance Management Program: In addition to healthcare transition, the Marine Corps also focuses on assisting servicemembers in their transition from DoD's to VA's benefits system. Our Transition Assistance Management Program (TAMP) provides resources and assistance to enable separating Marines and

their families to make a successful and seamless transition from military to civilian life.

TAMP provides information and assistance on various transition topics, including: employment, education and training benefits, determining health and life insurance requirements, financial planning, the benefits of affiliating with the Marine Corps Reserves, and veterans benefits and entitlements.

For our injured Marines, we provide TAMP services at a time and location to best suit their needs, whether at bedside at a military treatment facility or their home. In cases where the Marine is not in a condition to receive transition information but the family members are, assistance and services are provided to the family members. We have five full-time TAMP representatives at Marine Corps Base Hawaii who are prepared to help Marines at Tripler Army Medical Center one-on-one at their bedside.

Transition services are available to all Marines and their family members who are within 12 months of separation or within 24 months of retirement. On a space-available basis, separated Marines can attend workshops up to 180 days after their date of separation. Pre-separation counseling and the Transition Assistance Program workshops are mandatory for all separating Marines.

Other services include: career coaching employment and training assistance; individual transition plan career assessment; financial planning instruction in resume preparation, cover letter, and job applications; job analysis, search techniques, preparation, and interview techniques; Federal employment application information; information on Federal, State, and local programs providing assistance; veterans benefits; and the Disabled Transition Assistance Program.

In conclusion, severe injury has a traumatic impact on our Marines and their families. Not only are life and death at stake, but there are also significant disruptions to family systems for months and years to come. The Marine and his or her family will find themselves navigating new territory and facing possibly some of the greatest challenges of their lives.

Without a doubt, taking care of our wounded servicemembers and their families is one of the Marine Corps' top priorities. It is why we tackle mental and physical health issues before, during, and after deployments. The goal is for our Marines to get the information, services, resources, and assistance they need to be self-sufficient, contributing members of their communities.

On behalf of all the selfless, dedicated men and women who serve in our Armed Forces, I thank this Committee for your continued support during these demanding times. I want to specifically thank you for the recent Traumatic SGLI program. The idea began with this Committee and, without your efforts, would not be law today.

The Department of Defense, Department of Veterans Affairs, and all of the individual services are committed to keeping the treatment, recovery, and transition of our injured as their highest priority. As challenges arise, they will be addressed and resolved, and best practices will be instituted as they are developed. We must continue to partner and communicate to ensure the transition proc-

ess is a positive one, helping our veterans to face this next phase of their lives with optimism and confidence.

Again, I thank the Committee for its unwavering support.

[The prepared statement of Lieutenant General Osman follows:]

PREPARED STATEMENT OF LIEUTENANT GENERAL H.P. (PETE) OSMAN, U.S. MARINE CORPS, DEPUTY COMMANDANT FOR MANPOWER AND RESERVE

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The State of Hawaii has been the source of great help to the Marine Corps in the Global War on Terrorism (GWOT). Marine Corps Base Hawaii, including the Kaneohe Bay and Camp H.M. Smith installations, is home to over 16,000 Marines, Sailors, family members, and Marine Corps civilian employees. Tripler Army Medical Center in Honolulu is also an important facility for the Marine Corps, currently providing medical care to several injured Marines. The Spark M. Matsunaga VA Medical Center and Oahu VA health care clinic are also resources for our injured servicemembers. The State of Hawaii has also witnessed its share of casualties and injuries during GWOT, with 2 Marines with Hawaii homes of record killed in combat and 9 others injured. The Marine Corps is highly focused on caring for these and all injured Marines, ensuring that their family members are provided for and comforted in the wake of their injury, and, when necessary, assisting with their transition to civilian life.

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COMBAT/OPERATIONAL STRESS CONTROL (COSC)

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After deployment, we help with readjustment by providing briefs for Marines and families on how to recognize problems and seek help, and by screening redeployed Marines for mental health problems. Marine officers and NCOs receive training close to the time of redeployment on the normal stress of readjusting to life in garrison and of reuniting with family members. They also are taught how to identify their Marines who are having problems, and how to get them help. We have begun screening all returned Marines and sailors for a wide variety of health problems after they have been back home for 90–180 days, and those who screen positive are evaluated and treated. Family members also receive redeployment stress briefs, including information about how to take care of their own stress as they reunite with their Marine spouses, and how to know whether their spouse is experiencing a stress problem that requires attention.

To ensure COSC training participation, we have a system using the Marine Corps Total Force System for unit-level tracking by individual Marines during pre-deployment, re-deployment, and post-deployment. We have also implemented the Department of Defense pre-deployment and post-deployment health assessments, which facilitates early identification and treatment of persistent stress problems.

Another important component of COSC is our web-based information and referral tool, the "Leaders Guide to Managing Marines in Distress." The guide gives leaders the ability to help Marines at the point of greatest positive impact: Marine-to-Marine. It offers leaders at all levels information to resolve high-risk problems faced by Marines that could be detrimental to personal and unit readiness. The faster and more effectively these problems are solved, the more time the individual and unit will have to focus on the mission. The guide is separated into six major categories: deployment, family, personal, harassment, substance use, and emotional. Within these categories, there are 16 main problem areas that include an overview of the problem, risk factors, why Marines may not seek help, prevention strategies, resources, and Marine Corps guidance. The guide can be accessed at *http://www.usmc-mccs.org/leadersguide*.

The Marine Corps appreciates the Committee's attention to this important issue, and I commend your steadfastness in ensuring that servicemembers receive appro-

priate care, in terms of both prevention of combat stress and treatment. I can assure you the Marine Corps' commitment to the mental and emotional well-being of our force remains strong. We will continue to seek validation of our COSC program and closely interact with Commands to capture lessons learned and best practices for future improvements and adjustments.

CARE FOR INJURED MARINES

The Marine Corps has a long history of caring for its fallen and injured Marines. Many of the Marines and Sailors who have suffered extremely serious combat injuries would not have survived in previous wars. Due to improved combat equipment, forward-deployed trauma stations, and post-injury medical care, they are fortunately still with us. Nevertheless, their trauma still has a potentially devastating impact on them, their families and their future. Therefore, the Marine Corps places top priority on the health care of our returning, injured Marines.

Marine Casualty Services. Marines who are seriously wounded in Iraq or Afghanistan, once stabilized, are ordinarily transported first to National Naval Medical Center (NNMC) in Bethesda, MD. Based on lessons learned from the treatment and processing of servicemembers injured during OIF/OEF, we established a Marine Casualty Services (MCS) patient administration team at that facility under the leadership of a Marine officer. MCS at Bethesda is a team of 27 professionals dedicated to assisting every admitted Marine. The team is composed of surgeons, mental health specialists, nurses, case management specialists, and a VA benefits coordinator. The team helps with all facets of the servicemembers's care—from assisting with family members' travel and lodging, to filing all appropriate claims for entitlements, to ensuring medical records are transferred in a timely fashion. They collaborate with the hospital staff, family members and VA Medical Center staff on a daily basis in order to ensure a seamless transition of care and services. Intensive case management is a key component for post discharge and follow-up care. Continued communication and coordination between the Marine Corps Medical Treatment Facility Case Manager, Veterans Health Administration-DoD Liaison, VA Medical Center OEF/OIF Case Manager, and the Marine for Life—Injured Support representative, is absolutely crucial as our injured proceed through their recovery. To enhance continuity, clinical outcomes, and improve family support, the trauma team doctors at NNMC conduct weekly teleconferences with primary VA transfer sites. Because of the importance of the MCS, the Marine Corps has established teams at Andrews Air Force Base to meet all incoming medevac flights, a team at Walter Reed to provide onsite support for Marines receiving amputee rehabilitation, and personnel augmentation to the Joint Personal Effects Division at Aberdeen. These teams remain actively involved with the day to day care of our injured Marines and do their best to support and advocate for our Marines and families even after they transfer to a VA Medical Center or other facility.

Marine for Life—Injured Support. Marine for Life—Injured Support is a formal program instituted by our Commandant to assist injured servicemembers and their families. The concept of Injured Support gives renewed meaning to "Once a Marine, Always a Marine" and assures all Marines that they never truly leave the Corps. The goal of this program is to bridge the difficult gap between military medical care and transition to VA. The key is to ensure continuity of support through transition and, in combination with Office of the Secretary of Defense Military Severely Injured Center, to provide case management tracking for several years forward. As our injured Marines continue with their recovery, potentially transfer from active to veteran status, and assimilate back into their communities, Marine for Life—Injured Support will be their greatest supporter and advocate. This program has been in operation since last January with features that include advocacy within both DoD and external agencies, assistance with military disability processing and physical evaluation boards, assistance with employment, and improved VA handling of health care and benefit cases. On average, 30 percent of our discharged injured Marines who have been contacted request and receive assistance. Injured Support representatives interact with Marine Casualty Services on a weekly basis to provide program information and contact numbers to hospitalized Marines and family members. Marine for Life—Injured Support is living proof of our motto—"Semper Fidelis."

Health Insurance Portability and Accountability Act (HIPAA). While the Marine Corps is not a keeper of servicemembers medical records, it wants to make sure that MCS and Marine For Life—Injured Support follows the law's mandates. As such, these personnel have received training from the NNMC HIPAA Compliance Specialist, as well as online follow-up training. Moreover, all injured Marines receiving health care at DoD and VA installations are counseled on their HIPAA rights and

provided the necessary disclosure forms. In June 2005, DoD and VA signed MOU on the sharing of medical information, called the "HIPAA MOU."

TRANSITION ASSISTANCE

Our hope is that many of our injured Marines will be able to return to duty. Clearly, in many cases, this is not possible. Consequently, the Marine Corps and DoD, along with the help of VA, has developed several initiatives to assist servicemembers who, for whatever reason, transition back to civilian life.

Seamless Transition Program. The Marine Corps is an active participant in the DoD-VA Joint Seamless Transition program. VA established the program in coordination with the services to facilitate and coordinate a more timely receipt of benefits for injured servicemembers while they are still on active duty. There are VA social workers and benefit counselors assigned at eight Military Treatment Facilities (MTFs) that serve the highest volumes of severely injured servicemembers, including Walter Reed Army Medical Center and National Naval Medical Center in Bethesda. VA staff stationed at these MTFs brief servicemembers about the full range of VA benefits including disability compensation claims and health care. They coordinate the transfer of care to VA Medical Centers near their homes, maintain follow-up with patients to verify success of the discharge plan and ensure continuity of therapy and medications. These VA case managers also refer patients to VA benefits and vocational rehabilitation counselors. As of August 2005, more than 3,900 patients have received VA referrals at the participating military hospitals.

In order to enhance the important value of the Seamless Transition program, the Marine Corps recently assigned two field grade officers to the VA Seamless Transition Office. This has facilitated better integration of Marine Corps and VA handling of servicemembers cases, involving both VA health care and benefits delivery. These liaisons, with the help of other Marine for Life—Injured Support counselors and VA liaisons, also help ensure that all documents needed by VA are gathered to begin VA processing.

Many of the seriously injured Marines will already be under the VA umbrella for care and treatment by the time their case is finalized at the physical evaluation board. With the Marine Liaison Officers at the VA Seamless Transition Office, injured servicemembers are now provided better case management oversight throughout the transition process to VA. In many instances, the Marine Corps has expedited a Marine's separation, making them eligible to receive compensation from VA in 30 days instead of the 60+ days that was previously experienced. This Marine Corps effort has assisted not only Marines, but members of the other services too.

Transition Assistance Management Program. In addition to health care transition, the Marine Corps also focuses on assisting servicemembers in their transition from DoD's to VA's benefits system. Our Transition Assistance Management Program (TAMP) provides resources and assistance to enable separating Marines and their families to make a successful and seamless transition from military to civilian life. TAMP provides information and assistance on various transition topics, including: employment, education and training benefits, determining health and life insurance requirements, financial planning, the benefits of affiliating with the Marine Corps Reserves, and veteran's benefits and entitlements. For our injured Marines, we provide TAMP services at a time and location to best suit their needs, whether at bedside at a military treatment facility or their home. In cases where the Marine is not in a condition to receive transition information, but the family members are, assistance and services are provided to the family member. We have 5 full-time TAMP representatives at Marine Corps Base Hawaii, who are prepared to help Marines at Tripler Army Medical Center one-on-one at their beside.

Transition services are available to all Marines and their family members who are within 12 months of separation or within 24 months of retirement. On a space-available basis, separated Marines can attend workshops up to 180 days after their date of separation. Pre-separation counseling and the Transition Assistance Program workshops are mandatory for all separating Marines. Other services include:

- Career Coaching Employment and training assistance
- Individual Transition Plan Career assessment
- Financial planning Instruction in resume preparation, cover letter, and job applications
- Job analysis, search techniques, preparation and interview techniques
- Federal employment application information
- Information on Federal, State, and local programs providing assistance
- Veteran's benefits
- Disabled Transition Assistance Program

CONCLUSION

Severe injury has a traumatic impact on our Marines and their families. Not only are life and death at stake, but there are also significant disruptions to family systems for months and years to come. The Marine and his or her family will find themselves navigating new territory and facing possibly some of the greatest challenges of their lives. Without a doubt, taking care of our wounded servicemembers and their families is one of the Marine Corps' top priorities. It is why we tackle mental and physical health issues before, during, and after deployments. The goal is for our Marines to get the information, services, resources and assistance they need to be self-sufficient, contributing members of their communities.

On behalf of all the selfless, dedicated men and women who serve in our Armed Forces, I thank this Committee for your continued support during these demanding times. I want to specifically thank you for the recent Traumatic SGLI program. The idea began with this Committee and, without your efforts, would not be law today.

The Department of Defense, Department of Veterans Affairs, and all of the individual services are committed to keeping the treatment, recovery and transition of our injured as their highest priority. As challenges arise, they will be addressed and resolved, and best practices will be instituted as they are developed. We must continue to partner and communicate to ensure the transition process is a positive one, helping our veterans to face this next phase of their lives with optimism and confidence.

Again, I thank the Committee for its unwavering support.

Senator AKAKA. Thank you, General Osman.

General Mixon.

STATEMENT OF MAJOR GENERAL BENJAMIN R. MIXON, U.S. ARMY, COMMANDING GENERAL, 25TH INFANTRY DIVISION (LIGHT), SCHOFIELD BARRACKS, HAWAII

General MIXON. Mr. Chairman, Senator Akaka, and distinguished Members of the Committee, thank you for inviting me to testify. We at the 25th Infantry Division appreciate the opportunity to discuss the transition of our soldiers from active, Reserve, and National Guard duty to veterans status, an issue that is very important to us.

The 25th Infantry Division has had over 1,700 leave the military honorably over the past 6 months. We have found that these departed soldiers have had various degrees of interaction with VA, with most of the interaction being extremely helpful to both the soldier and the family members of the veterans. The most influential programs we've seen working are for soldiers who return early from deployment due to injury or illness, and soldiers who are medically discharged from the Army.

There are programs such as the Deployment Cycle Support process where the soldiers returning from deployment with their unit receive information about VA, and programs to inform separating soldiers and retirees within 180 days of discharge of their VA benefits and disability claim abilities through the Army Career and Alumni Program (ACAP) and the VA Benefits Delivery at Discharge (BDD) program. The ACAP and BDD programs inform all separating or retiring soldiers of their VA benefits due to their honorable service, including medical disability claims.

The VA Pacific Islands has a very thorough system in place for Army veterans who separate or retire from the 25th. Separating soldiers participate in the ACAP and BDD processes, where they are briefed by a representative from the VA on all VA programs available to them.

Following the briefing, every separating or retiring soldier is linked up with both a VA disability and a healthcare representa-

tive, who sit down with the soldier and his or her medical records to discuss all the available options. The VA representative goes page by page through the servicemembers's records to inform the soldier of any possible benefits that he or she can apply for from the VA.

Servicemembers can file their claims while still on active duty as long as they are within 180 days of separating or retiring. If they are not able to file a claim within that window, they can file their claim after they retire at the VA Regional Office closest to their residence. The VA immediately processes claims of service men and women who are still on active duty through the BDD program, so the VA encourages soldiers to file their claims as close as possible to within 180 days of discharge, with the goal to complete their claim prior to discharge.

Servicemembers are finding a majority of the portions of the VA BDD process efficient while other segments, such as final electronic cycle input of VA disabilities following a decision with award of compensation benefits, are slowing the process of receiving a disability check in conjunction with a retirement check.

One upcoming retiree said initiating his claim was very efficient; someone called him within a week of putting in his paperwork. This is considerably faster than it would have been had he not submitted his claim for benefits until after he had been discharged. It then took a month for him to see a VA doctor to assess his injuries which he received while still on active duty. He presently is still on active duty and waiting for VA to certify his claim so he can receive disability after retirement.

The overwhelming significance of the 25th Infantry Division working with the VA to assist in the transition of the soldiers and their families into civilian life and VA care and benefits is twofold. First, the claims are processed much faster while the soldier is on active duty, with decisions of benefits made in almost two-thirds less time than it takes for claims processed after departure from service. Second, the up-front knowledge of available VA programs and benefits can be a key decisionmaker for the soldier and his or her family of how to use these benefits immediately following discharge, and how to program their transition into a new lifestyle, based on available VA benefits.

Twenty-fifth Infantry Division soldiers who return early from deployment due to illness or injury receive assistance from the Tripler Managed Care Division and the recently formed Patient Family Assistance Team. These services provide the servicemembers with everything from medical care to financial services. The Patient Family Assistance Team was organized in 2004 by Tripler Army Medical Center and has been very successful thus far in aiding our troops.

The team has social workers, a physician, a VA benefits representative, liaisons with other military care facilities across the world, and a presiding officer who is the Chief of Patient Administration. The team also helps coordinate travel for dependents, personal and specialized care, housing, and financial services for each soldier.

The VA benefits representative became a great liaison between the VA Vet Center and Department of Army, helping facilitate di-

rect counseling referrals for dependents of those killed and service men and women suffering with symptoms of post-traumatic stress disorder.

This VA team member also plays a crucial role in facilitating a seamless transition of care between the military behavioral health staff and the VHA mental health professionals who are helping provide care to the numerous soldiers suffering from emotional trauma caused by combat. The VA social work staff has trained military personnel, and at times provided direct care for soldiers dealing with drug and alcohol abuse.

The Tripler Managed Care Division provides a case manager to each soldier. The case manager is an activated National Guard registered nurse who has successfully completed the case manager course and is on orders to Tripler Army Medical Center for this purpose. There are about 250 medical cases the Managed Care Division handles, with a ratio of approximately 1 case manager for 50 active duty soldiers.

The ratio is approximately 1 to 35 for Hawaii National Guard and Reservists who return to the island due to the fact that their care will most likely be longer term on the island, as opposed to active component soldiers moving back to the mainland for various reasons.

The case managers have daily interaction with soldiers and meet twice a month with the Patient Family Assistance Team to discuss any changes to or new benefits for soldiers to pass along information. The case managers direct the soldiers to the VA office in the hospital to make sure they get registered. They explain to the soldiers individually, based on their specific circumstances, the programs and benefits that apply to them and for which they are eligible.

One of the most important actions case managers take is ensuring no soldier leaves the hospital without the proper line of duty paperwork that is critical for future care and disability payments for which they may want to apply. The Managed Care Division also has a contracted social worker who is accustomed to working with soldiers who do not want to seek mental health or post-traumatic health treatment from military physicians.

Soldiers returning from deployment on schedule with their unit all must go through a reverse soldier readiness process in which they complete paperwork documenting their return from deployment, undergo a mental health screening, financial and housing processing, and other readiness items. One of the booths they must stop at has a health benefits advisor who gives them informational pamphlets on veterans assistance and TRICARE.

In order for soldiers to complete their reverse soldier readiness process, they must have the health benefits advisor's signature on their paperwork signifying they received the information. We have realized that many soldiers do not take the time to read this valuable information; their focus is solely on completing all re-deployment tasks and enjoying being home.

To better inform soldiers of their VA benefits, they attend various briefings and appointments on the third day of this process, after their 72-hour pass, to help them adjust to being back in Hawaii and in a garrison environment, and to help them get appoint-

ments for housing, finance, and vehicle pickup. On this day of briefings, one of them is given by a VA representative. The briefing is extremely informative and gives the soldiers all the information and points of contact necessary to use the VA.

Soldiers who may be medically discharged undergo a different process. They will first receive a permanent profile, documenting their permanent injury and/or illness. As soon as they receive this profile, they are required to attend a division and medical briefing to begin the medical board process, which ultimately will determine fitness for duty.

At the medical brief, they are informed about the VA programs and benefits they are entitled to and are referred to VA employees for benefit counseling and to complete benefit applications. This is especially significant for those who are eligible and need disability compensation. Some soldiers are referred to the VA's Vocational Rehabilitation Division where they receive contact vocational educational counseling.

The VA in Hawaii is doing tremendous things for the 25th Infantry Division and U.S. Army Hawaii soldiers. They provide extremely knowledgeable counselors and case managers to help every individual who returns from war and those who are retiring after a lifetime of service to the Nation. The soldiers in the 25th Infantry Division and U.S. Army Hawaii are fortunate to have such a dedicated staff at the Hawaii VA who are continually developing and improving their programs to better support our servicemembers.

[The prepared statement of Major General Mixon follows:]

PREPARED STATEMENT OF MAJOR GENERAL BENJAMIN R. MIXON, U.S. ARMY, COMMANDING GENERAL, 25TH INFANTRY DIVISION (LIGHT)

Mr. Chairman and distinguished Members of the Committee:

Thank you for inviting me to testify. We at the 25th Infantry Division appreciate the opportunity to discuss the transition of our Soldiers from Active, Reserve, and National Guard duty to veterans' status, an issue that is very important to us.

The 25th Infantry Division has had over 1700 Soldiers leave the military honorably over the past 6 months. We have found that these departed Soldiers have had various degrees of interaction with Veterans Affairs (VA), with most of the interaction being extremely helpful to both the Soldier and the family members of the veterans. The most influential programs we've seen working are for Soldiers who return early from deployment due to injury or illness, and Soldiers who are medically discharged from the Army. There are programs such as the Deployment Cycle Support process where the Soldiers returning from deployment with their unit receive information about VA, and programs to inform separating soldiers and retirees within 180 days of discharge of their VA benefits and disability claim abilities through the Army Career and Alumni Program (ACAP), and the VA Benefits Delivery at Discharge (BDD) program. The ACAP and BDD programs inform all separating/ retiring soldiers of their VA benefits due to their honorable service, including medical disability claims.

The VA Pacific Islands has a very thorough system in place for Army veterans who separate or retire from the 25th. Separating soldiers participate in the ACAP and BDD processes, where they are briefed by a representative from the VA on all VA programs available to them. Following the briefing, every separating/ retiring solder is linked up with both a VA disability and healthcare representative, who sit down with the Soldier and his or her medical records to discuss all the available options. The VA representative goes page by page through the servicemembers' records to inform the Soldier of any possible benefits that he/she can apply for from the VA. Servicemembers can file their claims while still on active duty, as long as they are within 180 days of separating or retiring. If they are not able to file a claim within that window, they can file their claim after they retire at the VA Regional Office closest to their residence. The VA immediately processes claims of servicemen and women who are still on active duty through the BDD program, so the VA en-

courages Soldiers to file their claims as close as possible to within 180 days of discharge, with the goal to complete their claim prior to discharge.

Servicemembers are finding a majority of the portions of the VA BDD process efficient while other segments, such as final electronic cycle input of VA disabilities following a decision with award of compensation benefits, are slowing the process of receiving a disability check in conjunction with a retirement check. One upcoming retiree said initiating his claim was very efficient; someone called him within a week of putting in his paperwork. This is considerably faster than it would have been had he not submitted his claim for benefits until after he had been discharged. It then took a month for him to see a VA doctor to assess his injuries which he received while still on active duty. He presently is still on active duty and waiting for VA to certify his claim so he can receive disability after retirement.

The overwhelming significance of the 25th Infantry Division working with the VA to assist in the transition of the Soldiers and their families into civilian life, and VA care and benefits is twofold: First, the claims are processed much faster while the Soldier is on active duty, with decisions of benefits made in almost two thirds less time than it takes for claims processed after departure from service. Second, the upfront knowledge of available VA programs and benefits can be a key decision-maker for the Soldier and his/her family of how to use these benefits immediately following discharge, and how to program their transition into a new life style, based on available VA benefits.

25th ID Soldiers who return early from deployment due to illness or injury receive assistance from the Tripler Managed Care Division and the recently formed Patient Family Assistance Team (PFAT). These services provide the servicemembers with everything from medical care to financial services. The Patient Family Assistance Team was organized in 2004 by Tripler Army Medical Center and has been very successful thus far in aiding our troops. The team has social workers, a physician, a VA benefits representative, liaisons with other military care facilities across the world, and a presiding officer who is the Chief of Patient Administration (PAD). The team also helps coordinate travel for dependents, personal and specialized care, housing, and financial services for each Soldier. The VA benefits representative became a great liaison between the VA Vet Center and Department of Army (DA) helping facilitate direct counseling referrals for dependents of those killed and servicemen and women suffering with symptoms of Post Traumatic Stress Disorder (PTSD). This VA team member also plays a crucial role in facilitating a seamless transition of care between the military behavioral health staff and the VHA Mental Health professionals who are helping provide care to the numerous Soldiers suffering from emotional trauma caused by combat. The VA Social Work staff has trained military personnel, and at times provided direct care for Soldiers dealing with drug and alcohol abuse. The Tripler Managed Care Division provides a Case Manager to each Soldier.

The Case Manager is an activated National Guard Registered Nurse (RN) who has successfully completed the Case Manager course and is on orders to Tripler Army Medical Center for this purpose. There are about 250 medical cases the Managed Care Division handles, with a ratio of approximately 1 Case Manager for 50 active duty Soldiers. The ratio is approximately 1 to 35 for Hawaii National Guard and Reservists who return to the island due to the fact that their care will most likely be longer term on the island as opposed to active component Soldiers moving back to the mainland for various reasons. The Case Managers have daily interaction with Soldiers and meet twice a month with the Patient Family Assistance Team to discuss any changes to or new benefits for Soldiers and to pass along information. The Case Managers direct the Soldiers to the VA office in the hospital to make sure they get registered. They explain to the Soldiers individually, based on their specific circumstances, the programs and benefits that apply to them and for which they are eligible. One of the most important actions Case Managers take is ensuring no Soldier leaves the hospital without the proper Line of Duty paperwork that is critical for future care and disability payments for which they may want to apply. The Managed Care Division also has a contracted social worker who is accustomed to working with Soldiers who do not want to seek mental health or post traumatic health treatment from military physicians.

Soldiers returning from deployment on schedule with their unit all must go through a reverse Soldier Readiness Process in which they complete paperwork documenting their return from deployment, undergo a mental health screening, financial and housing processing, and other readiness items. One of the booths they must stop at has a Health Benefits Advisor who gives them informational pamphlets on Veteran's Assistance and TRICARE. In order for Soldiers to complete their reverse Soldier Readiness Process, they must have the Health Benefits Advisor's signature on their paperwork signifying they received the information. We have realized that

many Soldiers do not take the time to read this valuable information; their focus is solely on completing all redeployment tasks and enjoying being home. To better inform Soldiers of their VA benefits, they attend various briefings and appointments on the third day of this process, after their 72 hour pass, to help them adjust to being back in Hawaii and in a garrison environment, and to help them get appointments for housing, finance, and vehicle pick-up. On this day of briefings, one of them is given by a VA representative. The briefing is extremely informative and gives the Soldiers all the information and points of contact necessary to use the VA.

Soldiers who may be medically discharged undergo a different process. They will first receive a permanent profile, documenting their permanent injury and/or illness. As soon as they receive this profile, they are required to attend a Division and medical briefing to begin the medical board process, which ultimately will determine fitness for duty. At the medical brief, they are informed about the VA programs and benefits they are entitled to and are referred to VA employees for benefit counseling and to complete benefit applications. This is especially significant for those who are eligible and need disability compensation. Some Soldiers are referred to the VA's Vocational Rehabilitation Division where they receive contact vocational educational counseling.

The VA in Hawaii is doing tremendous things for 25th Infantry Division and US Army Hawaii Soldiers. They provide extremely knowledgeable counselors and case managers to help every individual who returns from war and those who are retiring after a lifetime of service to the Nation. The Soldiers in the 25th Infantry Division and US Army Hawaii are fortunate to have such a dedicated staff at the Hawaii VA who are continually developing and improving their programs to better support our servicemembers.

Senator AKAKA. Thank you, General Mixon.

General Lee.

STATEMENT OF MAJOR GENERAL ROBERT G.F. LEE, ADJUTANT GENERAL, STATE OF HAWAII, DEPARTMENT OF DEFENSE

General LEE. Chairman Craig, Senator Akaka, and Members of the Senate Committee on Veterans' Affairs, I am Major General Robert G.F. Lee, the Adjutant General for the State of Hawaii. Within the State Department of Defense, there are four major divisions: the Hawaii Army and Air National Guard, State Civil Defense, and the Office of Veterans' Services (OVS). The Director of the Office of Veterans' Services is Colonel (Ret.) Edward Cruickshank, who previously testified before this Committee.

The Office of Veterans' Services is the single office in the State government responsible for the welfare of our veterans and their families. OVS serves as the liaison between Governor Linda Lingle and the veterans groups and organizations. They also act as an intermediary between the Department of Veterans Affairs and Hawaii's veterans.

The Department of Veterans Affairs latest data, as of September 2004, shows there are 107,310 veterans in the State of Hawaii. Taking another view, this means that more than 10 percent of our State's populations are veterans. The majority of them—about 72 percent—live on the island of Oahu, 13 percent reside on the island of Hawaii, 10 percent live on one of the 3 islands that comprise Maui County, and about 5 percent live on the island of Kauai.

Within this large veteran population, there are many World War II veterans, such as members of the famed 100th Battalion and the 442nd Regimental Combat Team. Prior to September 11, we faced a reduced veteran population due to the passing of many World War II veterans. Correspondingly, VA resources were also reduced.

However, as the Global War on Terrorism kicks into high gear, we will now see an increased veteran population with the call-up

of many Guard and Reserve units. Hawaii presents this situation on the high end of the spectrum. The reality is that 90 percent of our Army National Guard in the State of Hawaii have been called to active duty for service in Iraq and Afghanistan.

So the Hawaii Army National Guard stands about the highest in the Nation for the number of soldiers called up. Sir, the only major unit left that hasn't been called up is the band. And we have not only from Hawaii, but primarily our Polynesian Brigade Combat Team that have served in Iraq, and that's the major portion that's coming back right now.

I'm glad that my colleague General Mixon covered the details of what happens to our soldiers. They're treated just like Army soldiers, go through the same process on the demobilization, and get all the benefits and the tie-ins with VA. And it's been a great partnership. We know personally all the people in VA that we work with, and I think we really have a great advantage in the State of Hawaii.

But I think now that our partnership is going to be tested because earlier on, even in the two rotations in Afghanistan earlier on and one in Iraq, it has been mostly our aviation units that have gone first. But now we have the big bulk of the Brigade Combat Team coming back, and I just want to talk about two concerns that I have.

One is as the soldiers return, and we're very happy to have that final physical, the clearance, to establish this baseline so we know what the baseline is at, their state of health when they leave the service. But what's been happening with a lot of Guard combat units nationwide is the report of PTSD subsequently.

And I want to talk about the unit that—units from American Samoa and Saipan which we have our VA medical clinics not quite up and running with, and I'm not even sure in Saipan that we have that—that a lot of these soldiers, from their culture and the warrior culture is that to be brave and tough, we kind of—we can suck it up.

But I tell you, I've been receiving a lot of reports over the 1 year in Iraq where, thankfully, it's been a patrol run into another IED, treated for headache, and returned to duty. We've got real tough soldiers. But when will it occur that we find out that something is wrong with them?

So we're doing a lot of post—at drills, and getting the families together, and keeping family readiness groups intact so that we can find out that something is wrong within the family and they need help. So primarily the concern is for our more remote soldiers, when they go on back, that some of this psychological care might not be as quickly administered.

The second area is kind of an inequity in VA payments to the State of Hawaii to the families upon the death of a veteran. And in the interests of time, I'm just going to go with my written testimony. It's just that now with the Punchbowl being full, the State of Hawaii now bears the burden for many of the costs for burial of our veterans and the maintenance of the cemeteries.

Thank you again very much for your support, Senator.

[The prepared statement of Major General Lee follows:]

PREPARED STATEMENT OF MAJOR GENERAL ROBERT G.F. LEE, ADJUTANT GENERAL, STATE OF HAWAII, DEPARTMENT OF DEFENSE

Chairman Craig, Senator Akaka and Members of the Senate Committee on Veterans' Affairs, I am Major General Robert G. F. Lee, The Adjutant General for the State of Hawaii. Within the State Department of Defense, there are four major divisions: the Hawaii Army and Air National Guard, State Civil Defense and the Office of Veterans' Services (OVS). The Director of Office of Veterans' Service is Col (Ret) Edward Cruickshank who previously testified before this Committee.

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The Department of Veterans Affairs' latest data, as of September 2004, shows there are 107,310 veterans in the State of Hawaii. Taken another view, this means that more than 10 percent of our state's population are veterans. The majority of them—about 72 percent—live on the island of Oahu, 13 percent reside on the island of Hawaii, 10 percent live on one of the three islands that comprise Maui County, and about 5 percent live on the island of Kauai.

Within this large veteran population are many World War II veterans, such as members of the famed 100th Battalion and the 442nd Regimental Combat Team. Prior to Sept. 11 we faced a reduced veteran population due to the passing of many WWII veterans. Correspondingly, VA resources were also reduced. However, as the Global War on Terrorism kicks into high gear, we will now see an increased veteran population with the call up of many Guard and Reserve units. Hawaii presents this situation on the high end of spectrum. Nine of every ten soldiers in the Hawaii Army National Guard have been activated to serve in Iraq and Afghanistan. They served honorably and our largest unit, the 29th Brigade Combat Team, is returning to Hawaii after their yearlong deployments.

We must insure our soldiers are certified that they are healthy before these new veterans return to their civilian lives. The Office of Veterans Services partners with the Veterans Administration here during the soldiers demobilization process. The major work in this partnership is still untested as we care for our new veterans in the follow on years.

The United States government must take care of military members from enlistment, through their service years, to veterans' benefits and finally, death benefits. I come to you with two concerns.

My first and most important concern is the Veterans Administration services to all of our mobilized soldiers that served in Iraq and Afghanistan, especially, our neighbor island veterans and other Pacific Islander veterans from Saipan and American Samoa. We must insure that all veterans receive the health care necessary to treat Post Traumatic Stress Disorder (PTSD), especially in the remote areas. The VA has mini clinics in the neighbor islands that can service our veterans. I am hopeful that resources will be available should we need to rapidly expand these clinics. I have serious concerns for our soldiers returning to American Samoa and Saipan where VA clinics do not exist.

Another important part of VA care goes to the families upon the death of a veteran. Their burial shall be honorable with full military honors. I would like to point out inequities in this area for the State of Hawaii. The National Memorial Cemetery of the Pacific at Punchbowl is almost at capacity. There are no remaining burial plots at Punchbowl and they only accept inurnments. Inurnments will end in a few years as the existing columbarium becomes full. Veteran burials are now conducted at the State Veterans Cemetery in Kaneohe.

Currently the Veterans Administration reimburses the State $300 per burial. The $300 stipend has been in existence for many years. The actual cost incurred by the State is $1,100. We are asking the Veterans Administration to increase the burial reimbursement and recommends an amount of $900 per burial. This will allow the State to cover most of our expenses.

The National Cemetery of the Pacific at Punchbowl is a beautiful and well-kept facility. Punchbowl receives an annual budget of $2,000,000+ and a staff of 19 personnel to maintain its beauty. In comparison, the State Veterans Cemetery receives an annual budget of $500,000 and has a staff of 6 personnel to maintain the facility. The State's veterans cemetery is larger than Punchbowl.

We believe the cost sharing of annual maintenance is appropriate and recommends a 40 percent Federal and 60 percent State split. This will allow the State to bring our Kaneohe facility up to the Punchbowl standard. We owe it to our deceased veterans and their families to have a beautiful, tranquil final resting place.

I thank you for your time. Are there any questions?

Senator AKAKA. Thank you. Thank you, General Lee.

[Applause.]

Senator AKAKA. Colonel Horn.

STATEMENT OF COLONEL MATTHEW HORN, DEPUTY COMMANDER, U.S. ARMY RESERVE, COMMANDER, 9TH REGIONAL READINESS COMMAND

Colonel HORN. Good morning, Senator Akaka, Members of the Committee. I'm Colonel Matthew Horn, and I'm the Deputy Commander of the 9th Regional Readiness Command, the 9th RRC. My commander, Brigadier General Ma, and I both appreciate the opportunity to testify before this Committee. General Ma's duties unfortunately require him to remain on the Island of Oahu this morning, but he sends his warm regards and his mahalo for all of the fine support that you've provided our soldiers and our veterans over the years.

As you are probably aware, the 9th Regional Readiness Command is responsible for Army Reserve units in American Samoa, Guam, Saipan, Alaska, and Hawaii. Additionally, many of our members live and work in Japan, Korea, and other Pacific Rim countries. We are responsible for 3,400 soldiers serving proudly in the Pacific and other parts of the world. We refer to ourselves proudly as the Pacific Army Reserves.

This morning I will limit my comments to the issue of returning 9th RRC Army Reserve veterans and the necessity for collaboration between the Department of Defense and the Veterans Health Administration to prepare for their future needs.

The 9th RRC's Army Reserve soldiers are still early in the redeployment cycle. The 411th Engineer Battalion returned last summer. The 793rd Engineer Detachment has just returned to American Samoa. The 100th Battalion, 442nd Infantry is redeploying as we speak. The 322nd Civil Affairs Brigade is expected back next summer. The 1101st Garrison Support Unit will continue on active duty at Schofield Barracks until later this year.

In addition to these larger units, many smaller units and portions of units and individuals have also been deployed. Additional units and soldiers of the 9th RRC are expected to be deployed some time next year and in future years.

We have been—there have been approximately 1,030 9th RRC soldiers who have returned from active duty, and there are approximately 1,180 9th RRC soldiers still mobilized. So within a year, two-thirds of the Pacific-based 9th RRC will have served on active duty in support of the Global War on Terrorism. We are just beginning to learn about our returning soldiers' and future veterans' specific needs for veterans services.

There are approximately 26 Army Reserve soldiers currently in the medical retention processing unit, the MRPU, on Oahu on continued active duty for evaluation and treatment of serious medical conditions. While assignment to the MRPU is for 179 days with a possibility of extensions, we think it may be a while before these soldiers will need to assess what their VA needs will finally be.

These 26 individuals possess the most severe medical conditions that have appeared among our soldiers to date. There are many

other soldiers whose conditions may not yet have manifested themselves and may not do so for months or years.

While it may be difficult to predict the exact numbers of types of conditions that may appear, we can anticipate seeing certain types of problems such as back and leg injuries, hearing injuries, perhaps post-traumatic stress disorders, based on the nature of the operations we've been involved in.

Our latest returning group of soldiers, the 100th Battalion, has really been in the thick of things with the 29th Brigade Combat Team, and we anticipate that we may have more needs among this group of soldiers. The bottom line is while it may be too early at this point in the redeployment cycle to know exactly what our utilization rate of VHA services will be, we know that they will be greater.

We should anticipate that the number of individuals needing these services in the Pacific region will very likely be greater than in previous years by the mere fact of our soldiers joining the ranks of veterans in the 9th RRC's area of operations.

Again, while it may not be possible to predict the specific number of Army Reserve soldiers who will need to access VHA's services in the future, it is critical that we work with the VA, as we are, to ensure that we understand the processes and the procedures to enable our returning soldiers to receive care through the current VHA systems. Also, we must plan for our soldiers' needs throughout our entire area of operations, including our remotest locations in American Samoa and Saipan where resources are more limited.

We look forward to working together with the Veterans Administration to care for these new veterans. I thank you again on behalf of General Ma and myself for all of the care that you have shown to our soldiers and our veterans. I'd be pleased later to answer any questions you may have.

[The prepared statement of Colonel Horn follows:]

PREPARED STATEMENT OF COLONEL MATTHEW HORN, DEPUTY COMMANDER, U.S. ARMY RESERVE, COMMANDER, 9TH REGIONAL READINESS COMMAND

Good morning. I appreciate being given the opportunity to speak before the Senate Committee on Veterans' Affairs. I am COL Matt Horn and I am the Deputy Commander with the 9th Regional Readiness Command. As you are probably aware, the 9th RRC is responsible for Army Reserve units in American Samoa, Guam, Saipan, Alaska and Hawaii. Additionally, many of our members live and work in Japan, Korea and other Pacific Rim countries. We are responsible for 3400 soldiers serving proudly in the Pacific and other parts of the world.

This morning I will limit my comments to the issue of returning Army Reserve servicemembers and the collaboration between the Department of Defense and the Veterans Health Administration.

The Army Reserve is still early in the redeployment cycle. The 793rd Engineer Detachment just returned. The 411th Engineer Battalion returned in Summer, 2005. The 100th Infantry Battalion is expected back in early 2006 and the 322nd Civil Affairs Brigade is expected back in Summer, 2006. The 1101st Garrison Support Unit is expected to continue on Active Duty at Schofield Barracks until early 2006. In addition to these larger units, smaller units or portions of units and individuals have been deployed. Additional units of the Army Reserve are expected to be deployed sometime next year. There have been approximately 1030 individuals returned from active duty to date and there are approximately 1180 personnel still mobilized.

Other than routine dental care, there has been no significant need for Army Reserve personnel to utilize Veterans Health Administration services yet. There are approximately 26 Army Reserve personnel in the Medical Retention Processing Unit and being continued on Active Duty for evaluation and or treatment. The average

"days left" in MRPU status is 130 days. Since assignment to the MRPU is for 179 days with a possibility of extensions, it may be a while before these soldiers will need to access Veterans Health Administration services. These 26 individuals represent the most severe conditions which have present impact on their performance of duty. Many servicemembers may have conditions that have not yet manifested itself and may not do so for months or years. While it would be difficult to predict numbers at this point, we can anticipate seeing certain types of problems such as back and leg injuries and post traumatic stress disorders. The first group returning, the 100th Infantry Battalion, has been in the thick of things, so we can anticipate more problems with this group.

The bottom line is that it is too early, at this point in the redeployment cycle, to know what the Army Reserve utilization of VHA services will be. However, we should anticipate that the number of soldiers needing those services will very likely be greater than in previous years.

Anticipating a greater need for VHA services, we need to focus on availability and accessibility of services. VHA services are very limited on Hawaiian Islands other than Oahu and on Guam. We also know that VHA services are non-existent on American Samoa and Saipan. It is estimated that 46 percent of presently deployed personnel are from locations other than Oahu. Of the 26 personnel in the MRPU, 12 are from American Samoa. Of the returning soldiers from the 100th Infantry Battalion, 300 are from American Samoa. There has been some discussion about establishing a VHA clinic in American Samoa. This idea is worthy of consideration. However, it should be noted that this is only a partial solution to the problem of access of medical care on American Samoa. For example, if the VHA clinic does not have a specific service that a soldier needs and there is no TRICARE network (as is the case in American Samoa), the soldier will still not have access to services and may need to come to Oahu for follow-up care.

While it may not be possible to predict the specific number of Army Reserve personnel who will need to access VHA services in the future, we can predict that there will be shortfalls in places such as American Samoa. It is critical to plan for, develop and establish VHA services in areas other than Oahu.

Thank you. I would be pleased to answer any questions you may have.

Senator AKAKA. Thank you very much.

[Applause.]

Senator AKAKA. Secretary Perlin.

STATEMENT OF HON. JONATHAN B. PERLIN, M.D., PH.D., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY ROBERT WIEBE, M.D., VA NETWORK DIRECTOR, VISN 21, SIERRA PACIFIC NETWORK; JAMES HASTINGS, M.D., DIRECTOR, VA PACIFIC ISLANDS HEALTH CARE SYSTEM; AND STEVEN A. MACBRIDE, M.D., CHIEF OF STAFF, VA PACIFIC ISLANDS HEALTH CARE SYSTEM

Dr. PERLIN. Aloha kakahiaka.

[Applause.]

Senator AKAKA. You heard that.

Dr. PERLIN. And mahalo nui loa, Senator Akaka, for the opportunity to appear here before you today to discuss the care of veterans here in Hawaii, and also the care of those servicemembers upon whom their return become veterans.

Senator Akaka, I greatly appreciate your holding hearings not only here on the Big Island but throughout other islands of Hawaii this week. I've learned a great deal about the care that's being given, the compassion and excellence that's demonstrated throughout the islands. I visited this morning our Community-Based Outpatient Clinic here in Hilo, and I'm pleased to go back knowing that the quality of care is very, very high and the compassion and sense of community is absolutely unsurpassed anywhere in VA.

I thank you and Chairman Larry Craig for your leadership, your advocacy, and your passion and commitment to veterans throughout our great country, and your passion especially for those veterans right here in the State of Hawaii.

Senator, I can perhaps inform veterans of the Big Island two important improvements that we're making to help VA provide them with the exceptional healthcare that they've earned. First, I'm pleased to note that Hawaii will build its first State Veterans Home here in Hilo, providing nursing home and domiciliary care to eligible veterans. VA is contributing $20 million, or approximately two-thirds of the construction cost, to partner with the State in constructing a 95-bed facility on the site of the former Hilo Hospital.

I thank you and the State delegation for all of your support and leadership in bringing that to fruition. It was indeed gratifying to drive by this morning and see construction in progress and dirt flying. We hope that that facility will open in the spring of 2007, and we look forward to this new collaboration.

Second, VA currently maintains two outpatient clinics on the Big Island, at Hilo, as I mentioned, and at Kailua-Kona as well. And we have plans to renovate both clinics this year. We'll be moving the Kailua-Kona Clinic to a larger facility, and we'll spend nearly half a million dollars to outfit the new space.

We also have plans to renovate further the Hilo outpatient clinic this year, and we're interested in acquiring the Army Reserve Center in Hilo that has been identified for closure so that we might relocate both the clinic and the Hilo Vet Center there in the future should that become available.

Our Hilo and Kailua-Kona Vet Centers provide counseling, psychological support, and outreach to veterans with readjustment issues. And we plan in the near future to begin a formal substance abuse treatment program right here in Hilo.

I should note also the move of our PTSD Residential Rehabilitation Program from Hilo to Honolulu. Our PTSD residential rehab program was established in Hilo about 10 years ago to meet the needs of veterans with chronic PTSD who would benefit from specialized residential treatment care.

And over the years, approximately 830 veterans have been treated at that center. Many of these patients, nearly 75 percent, I should note, were not in fact from the Big Island, and we expect, of course, to receive some veterans from the Global War on Terror with PTSD or acute stress disorder and expect them to seek services from VA. And most of these veterans reside in Oahu, and locating the inpatient unit there allows a number of benefits, including important synergies, with other medical services available at Tripler. Consequently, we're in the process of moving that program to Honolulu.

Besides their outpatient clinic and Vet Centers here at Hilo and in Kona, VA provides care to Hawaii's 113,000 veterans at four additional locations, the absolutely spectacular Spark M. Matsunaga Ambulatory Care Center and the Center for Aging on the campus of Tripler Army Medical Center in Honolulu, and as well at Community-Based Outpatient Clinics on Kauai, on Maui, and also in Agana, Guam.

At all of our centers of care, we provide direct primary care, including preventive services and health screenings, and of course mental health services. In hearings this week, we have discussed improvements, and VA is sending clinicians and support staff to provide services, particularly on the islands of Molokai and Lanai, and augmenting the services with increased outreach through telemedicine and telehealth programs. And we're very pleased to announce just this week an additional $1 million in funding to support tele-mental health services and other services through that outreach program.

I'd also note that in addition to the Vet Centers here in Hilo and in Kona, we have Vet Centers on Oahu, on Kauai, and in Maui. And we operate a formal substance abuse treatment program in Honolulu as well.

Inpatient mental health services are provided by VA staff on a ward within Tripler, and I had the great pleasure of visiting that unit yesterday and seeing again the excellence in quality and the commitment that is equally compassionate.

We rely on Tripler for emergency room care, acute medical surgical inpatient care, outpatient specialty care, and ancillary services. And all of our sites in Hawaii are authorized to provide DoD beneficiaries care as TRICARE providers as part of the seamless transition initiative between VA and DoD.

I'd just note that I want to thank General Osman and the Commandant of the Marine Corps, as well for your great commitment to the seamless transition program, and the commitment of the other services at similarly high levels as well.

Veterans who have particularly grievous injuries are also treated at our polytrauma unit in Palo Alto, California, part of VISN 21 or the network that Dr. Wiebe is the director of that also includes the VA Pacific Islands Health Care System.

In conclusion, with the great support and leadership of Senator Akaka, who I would be remiss if I didn't acknowledge his role in bringing to fruition the new State Veterans Home and also the $83 million in funding that were really the basis for building the Spark M. Matsunaga Ambulatory Care Center and Center for Aging.

I want to thank you for your leadership and that of other Members of Congress, our Chairman of the Senate Veterans' Affairs Committee, Senator Larry Craig, to help us provide services to veterans of Hawaii at unprecedented levels, and services that are equally excellent throughout this great State and throughout the country.

Thank you very much.

[The prepared statement of Dr. Perlin follows:]

PREPARED STATEMENT OF HON. JONATHAN A. PERLIN, M.D., PH.D., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee, mahalo nui loa for the opportunity to appear before you today to discuss the state of VA care in the Hawaii. It is a privilege to be here on the Island of Hawaii—The Big Island—to speak and answer questions about issues important to veterans residing in Hawaii.

First, Mr. Chairman, I would like to thank you for your outstanding leadership and advocacy on behalf of our Nation's veterans. During your tenure as Chairman of this Committee, you have clearly demonstrated your commitment to veterans by acting decisively to ensure the needs of veterans are met. In addition, I appreciate your interest in and support of the Department of Veterans Affairs (VA).

I also would like to express my appreciation and respect for Senator Akaka, Ranking Member of this Committee. Along with his colleague, Senator Inouye, Senator Akaka has done so much for the veterans residing in Hawaii and other islands in the Pacific region. As I will highlight later, his vision, guidance and assistance have directly led to an unprecedented level of health care services for veterans, construction of state-of-the-art facilities in Honolulu and remarkable improvements in access to health care services for veterans residing on neighbor islands, including the Big Island.

Today, I will briefly review the VA Sierra Pacific Network that includes Hawaii and the Pacific region; provide an overview of the VA Pacific Islands Health Care System (VAPIHCS) and the VA facilities here in the Big Island; highlight issues of particular interest to veterans residing in Hawaii, including the relocation of the Post-traumatic stress disorder Residential Rehabilitation Program (PRRP) from Hilo to Honolulu on the campus of the Tripler Army Medical Center (AMC), veterans returning from Iraq and Afghanistan, substance abuse treatment programs and the future State Veterans Home; and address any questions posed by Members of the Committee.

VA SIERRA PACIFIC NETWORK (VISN 21)

The VA Sierra Pacific Network (Veterans Integrated Service Network [VISN 21]) is one of 21 integrated health care networks in the Veterans Health Administration (VHA). The VA Sierra Pacific Network provides services to veterans residing in Hawaii and the Pacific Basin (including the Philippines, Guam, American Samoa and Commonwealth of the Northern Marianas Islands), northern Nevada and central/northern California. There are an estimated 1.25 million veterans living within the boundaries of the VA Sierra Pacific Network.

The VA Sierra Pacific Network includes six major health care systems based in Honolulu, HI; Palo Alto, CA; San Francisco, CA; Sacramento, CA; Fresno, CA and Reno, NV. Dr. Robert Wiebe serves as director and oversees clinical and administrative operations throughout the Network. In Fiscal Year 2005 (FY05), the Network provided services to 227,000 veterans. There were about 2.8 million clinic stops and 24,000 inpatient admissions. The cumulative full-time employment equivalents (FTEE) level was 8,200 and the operating budget was about $1.3 billion, which is an increase of $378 million since 2001.

The VA Sierra Pacific Network is remarkable in several ways. In fiscal year 2005, the Network was the only VISN in VHA to meet the performance targets for all six Clinical Interventions that directly address adherence to evidence-based clinical practice. The Network hosts 11 (out of 65) VHA Centers of Excellence—the most in VHA. The VA Sierra Pacific Network also has the highest funded research programs in VHA. Finally, VISN 21 operates one of four Polytrauma units that are dedicated to addressing the clinical needs of the most severely wounded Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) veterans.

VA PACIFIC ISLANDS HEALTH CARE SYSTEM (VAPIHCS)

As noted above, VAPIHCS is one of six major health care systems in VISN 21. VAPIHCS is unique in several important aspects: its vast catchment area covering 2.6 million square-miles (including Hawaii, Guam, American Samoa and Commonwealth of the Northern Marianas); island topography and the challenges to access it creates; richness of the culture of Pacific Islanders; and the ethnic diversity of patients and staff. In fiscal year 2005, there were an estimated 113,000 veterans living in Hawaii (9 percent of Network total).

VAPIHCS provides care in six locations: Ambulatory Care Center (ACC) and Center for Aging (CFA) on the Tripler AMC campus in Honolulu; and community-based outpatient clinics (CBOCs) in Lihue (Kauai), Kahului (Maui), Kailua-Kona (Hawaii), Hilo (Hawaii) and Agana (Guam). VAPIHCS also sends clinicians and support staff from these locations to provide services on Lanai, Molokai and American Samoa. The inpatient post-traumatic stress disorder (PTSD) unit formerly in Hilo is in the process of relocating to Honolulu. In addition to VAPIHCS, VHA operates five Readjustment Counseling Centers (Vet Centers) in Honolulu, Lihue, Wailuku, Kailua-Kona and Hilo that provide counseling, psychosocial support and outreach.

Dr. James Hastings was recently appointed Director, VAPIHCS. Dr. Hastings has impressive credentials, including tenure as Chair, Department of Medicine, John A. Burns School of Medicine, University of Hawaii, and Commanding General at Walter Reed AMC and Tripler AMC. I am excited about the possibilities that his tenure as Director at VAPIHCS brings.

In fiscal year 2005, VAPIHCS provided services to 18,300 veterans in Hawaii (8 percent of Network total). There were 194,000 clinic stops in Hawaii during fiscal

year 2005 (7 percent of Network total), an increase of 36 percent since fiscal year 2000. The cumulative FTEE for the health care system was 478 employees. The budget for VAPIHCS (including General Purpose, Specific Purpose and Medical Care Cost Funds [MCCF]) has increased from $53 million in fiscal year 1999 to $102 million in fiscal year 2005 (about 8 percent of Network total). In addition, VISN 21 provided over $20 million in supplemental funds to VAPIHCS over the past two Fiscal Years to ensure VAPIHCS met its financial obligations.

VAPIHCS provides or contracts for a comprehensive array of health care services. VAPIHCS directly provides primary care, including preventive services and health screenings, and mental health services at all locations. Selected specialty services are also currently provided at the Honolulu campus and to a lesser extent, at CBOCs. VAPIHCS recently hired specialists in gero-psychiatry, gastroenterology, ophthalmology and radiology. VAPIHCS is actively recruiting additional specialists in cardiology, orthopedic surgery and urology. Inpatient long-term care is available at the Center for Aging. Inpatient mental health services are provided by VA staff on a ward within Tripler AMC and at the PTSD Residential Rehabilitation Program (PRRP) that was formerly here in Hilo (now relocating to Honolulu). VAPIHCS contracts for care with Department of Defense (DoD) (at Tripler AMC and Guam Naval Hospital) and community facilities for inpatient medical-surgical care.

The current constellation of VA facilities and services represents a remarkable transformation over the past several years. Previously, the VAPIHCS (formerly known as the VA Medical and Regional Office Center [VAMROC] Honolulu) operated primary care and mental health clinics based in the Prince Kuhio Federal Building in downtown Honolulu and CBOCs on the neighbor islands that were staffed primarily with nurse practitioners. Senator Akaka and his colleagues in Congress approved $83 million in Major Construction funds to build a state-of-the-art ambulatory care center and nursing home care unit on the Tripler AMC campus and these facilities were activated in 2000 and 1997, respectively. VISN 21 allocated nearly $17 million from FY98–FY2000 to activate these projects. VISN 21 also provided dedicated funds (e.g., $2 million in FY01) to enhance care on the neighbor islands by expanding/renovating clinic space and adding additional staff to ensure there are primary care physicians and psychiatrists at all CBOCs.

BIG ISLAND CBOCS

VA operates CBOCs in both Hilo (1285 Waianuenue Avenue, Suite 211, Hilo, HI, 96720) and Kailua-Kona (75–5995 Kuakini Highway, Suite 413, Kailua-Kona, HI, 96740). VHA also operates Readjustment Counseling Centers ("Vet Centers") in Hilo (120 Keawe Street, Suite 201, Hilo, HI, 96720) and Kailua-Kona (co-located with the Hilo CBOC).

The Big Island's CBOCs serve an estimated island veteran population of 15,309. In fiscal year 2005, 3,980 veterans were enrolled for care on the island and 2,929 received care ("users") at Big Island VA facilities. The market penetrations for enrollees and "users" are 26 percent and 19 percent, respectively, and compare favorably with rates within VISN 21 and VHA.

Hilo CBOC. Many veterans view this clinic like an old-fashioned doctor's office. In a recent letter, a retired Marine veteran wrote, "I am a 100 percent disabled veteran of the Vietnam War and suffer from several war-related illnesses. This letter is not about me, but about the care that the people at our Hilo primary care unit dispense. I do not know all the staff, but the ones I do know have helped me enjoy a healthier life and are some of the most caring, friendly and knowledgeable individuals I have ever met in VA. You can be proud of them and the jobs they do."

VAPIHCS spent about $100 thousand in fiscal year 2001 to remodel the Hilo CBOC and plans to spend additional funds in fiscal year 2006 to further renovate the clinic. VA has also expressed interest in acquiring an Army Reserve Center in Hilo from the 2005 Base Realignment and Closure (BRAC) process and potentially relocating the clinic and Vet Center to this location in the future.

The current authorized full-time employment equivalents (FTEE) level at the Hilo CBOC is 11.0, including two full-time primary care physicians and a psychiatrist. With this staff, the Hilo CBOC provides a broad range of primary care and mental health services. The Hilo CBOC also has a formal home-based primary care (HBPC) program that provides clinical services in the homes of veterans. Additional staff will be added from the former PRRP to increase mental health services (see discussion below).

VAPIHCS provides specialty care services at the clinic by sending VA staff from Honolulu and other VA facilities in California. Services provided by clinicians traveling to Hilo include cardiology, geriatrics, nephrology, neurology, optometry, orthopedics, rheumatology and urology. If veterans need services not available at the clin-

ic, VAPIHCS arranges and pays for care in the local community (e.g., Hilo Medical Center), Honolulu (including Tripler AMC) or VA facilities in California. In fiscal year 2005, VA spent more than $7.5 million in non-VA care in the private sector (i.e., not including costs at other VA or DoD facilities) for residents of the Big Island.

In fiscal year 2005, the Hilo CBOC recorded 8,843 clinic stops, representing a 10 percent increase from fiscal year 2000 (i.e., 8,072 stops). The clinic has short waiting times for new patients with very few veterans waiting more than 30 days for their first primary care appointment. The Hilo HBPC program recorded 678 clinic stops for providing home care to veterans residing on the east side of the island.

Kailua-Kona CBOC. Veterans at the Kailua-Kona CBOC are also very satisfied with the care they receive. For example, a veteran recently wrote, "I couldn't be more pleased with the way Kona VA handled my care. All of the staff are very helpful, and will take that extra step to make me feel comfortable, and answer all of my concerns and questions. The feeling I get when I go to my veteran's center or even to Tripler hospital is like I'm going home to my family."

In part because of high patient satisfaction, the workload at the Kailua-Kona CBOC has grown over the years and staff needs additional space to meet increasing demand for VA services. In fiscal year 2006, VAPIHCS will relocate the Kailua-Kona CBOC to a larger facility and spend nearly $500 thousand to renovate the new space.

The current authorized full-time employment equivalents (FTEE) level at the Kailua-Kona CBOC is 10.0, including a full-time primary care physician, psychiatrist and nurse practitioner. With this staff, the Kailua-Kona CBOC provides a wide array of primary care and mental health services. The Kailua-Kona CBOC also has a formal home-based primary care (HBPC) program that provides clinical services in the homes of veterans.

VAPIHCS provides specialty care services at the clinic by sending VA staff from Honolulu and other VA facilities in California. Services provided by clinicians traveling to Kailua-Kona include cardiology, geriatrics, nephrology, neurology, optometry, orthopedics, rheumatology and urology. If veterans need services not available at the clinic, VAPIHCS arranges and pays for care in the local community (e.g., Kona Community Hospital) and Honolulu (including Tripler AMC). As noted before, in fiscal year 2005, VA spent more than $7.5 million in non-VA care in the private sector (i.e., not including costs at other VA or DoD facilities) for residents of the Big Island.

Clinic staff also occasionally refers patients to VA facilities in California. Access to other VA facilities was especially important to a veteran who wrote, "The veteran's health center in Kona has not only helped me get my prescription drugs at a lower cost, but last year they helped me go to the Western Blind Rehabilitation Center in Palo Alto to learn how to cope with my blindness. For the first time in many years, I have confidence to do things I never thought I could do without sight."

In fiscal year 2005, the Kailua-Kona CBOC recorded 6,888 clinic stops, representing a 26 percent increase from fiscal year 2000 (i.e., 5,456 stops). The clinic has short waiting times for new patients with very few veterans waiting more than 30 days for their first primary care appointment. The Hilo HBPC program recorded 609 clinic stops for providing home care to veterans residing on the west side of the island.

SPECIAL ISSUES

PTSD Residential Rehabilitation Program (PRRP). The PRRP was established in Hilo about 10 years ago to meet the needs of veterans with chronic PTSD who would benefit from a specialized inpatient program. Over the years, approximately 830 veterans, mostly Vietnam era veterans, have been treated at the center. The vast majority of these patients—nearly 75 percent—did not originate from the Big Island. Although the PRRP in Hilo fulfilled its original goals, the demographics and epidemiology associated with PTSD is changing as result of the war in southwest Asia. VA expects an increasing number of OIF/OEF veterans with PTSD or Acute Stress Disorder (ASD) to seek services from VA. Most of these veterans reside in Oahu and the best treatment for them is outpatient care that integrates treatment with their families and community.

Consequently, VA is moving the PRRP from Hilo to Honolulu to provide enhanced mental health services to veterans with both acute and chronic PTSD. The 16-bed unit will be maintained and initially relocated to the 5th floor of Tripler AMC. VAPIHCS expects to activate the unit in early 2006, once minor renovations have been completed and staff has been relocated from Hilo and/or hired. VAPIHCS has

submitted a $6.9 million Minor Construction project for fiscal year 2007 to construct a combined inpatient and outpatient PTSD facility on the Tripler AMC campus. VA will also augment outpatient PTSD services, both in Honolulu at the new PRRP location and in Hilo at the local CBOC. VAPIHCS will add four or five new staff to the Hilo CBOC, including a clinical nurse specialist, addiction therapist and psychiatric social worker. As a result of this redesign, VA will provide a higher level of service and greater accessibility for existing and new patients with PTSD. The relocation will also facilitate greater collaboration with DoD.

OIF/OEF outreach. At the groundbreaking ceremony for the State Veterans Home here in Hilo, Senator Inouye referenced the three-word motto of the U.S. Military Academy and noted, "'Duty, honor, country' is not a one-way proposition." VA fully understands this and its commitment to our newest veterans—those who bravely served in Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF). We stand ready to meet their needs.

VA estimates up to 15,000 residents of Hawaii have been deployed to Afghanistan and Iraq as active duty personnel, Reservists or Hawaii National Guard personnel. Major General Lee, Adjutant General, State of Hawaii, Department of Defense (DoD), reports there are 2,200 Reservists and National Guard serving in Iraq and Afghanistan.

All VAPIHCS sites of care, including CBOCs, are authorized to provide care to DoD beneficiaries as Tricare providers. This allows OIF/OEF veterans living in Oahu or neighbor islands to utilize VA services, including mental health care. In fiscal year 2005, VAPIHCS provided care to 393 OIF/OEF veterans, with the facilities in Honolulu treating 345 of these veterans. Veterans residing in Hawaii also have access to the Polytrauma Unit at the VA Palo Alto Health Care System. This is one of four specialized units designed to meet the needs of the most severely injured OIE/OEF veterans and active duty personnel.

VAPIHCS is preparing for additional OIF/OEF veterans. The facility has appointed an OIF/OEF outreach coordinator. As noted earlier, VAPIHCS is revamping its PTSD program to meet the special needs of OIF/OEF veterans. Additionally, VAPIHCS has requested additional funds through the national VHA mental health funding initiative in fiscal year 2006 to hire dedicated staff for OIF/OEF outreach and enhanced services at CBOCs, including Hilo. Although VAPIHCS cannot forecast the exact number of OIF/OEF veterans who will seek care from VA, I am confident VAPICHS will be able to meet the needs of our newest veterans and provide them safe, effective and accessible care.

Substance abuse. VAPIHCS operates a formal Substance Abuse Treatment Program (SATP) at the ACC in Honolulu. SATP staff includes a board-certified addiction psychiatrist, two clinical nurse specialists, social worker and two addiction therapists. Staff treats patients with substance abuse issues related methamphetamine, opioids, alcohol and other substances. In fiscal year 2005, VAPIHCS recorded 4,841 clinic stops in SATP. In addition, VAPIHCS collaborates with the Veterans in Progress (VIP) program operated by U.S. VETS at Barbers Point on Oahu.

Currently, VAPIHCS does not have specialized substance abuse treatment programs at the CBOCs on neighbor islands. Services are provided by VA psychiatrists at the CBOCs and through referrals to community providers or VA SATP in Honolulu. VAPIHCS recognizes that in some locations, this may not be sufficient. As an example, in the Big Island, the use of crystal methamphetamine (or "ice") is a significant problem. As noted earlier, as part of the restructuring of the PRRP, VA will begin a formal substance abuse treatment program in Hilo this year. At other locations, VAPIHCS will utilize telehealth technology and add staff as demand dictates and the availability of resources allow.

State Veterans Home. The State of Hawaii is planning to build its first State Home in Hilo. This will be the first State of Hawaii facility to provide nursing home and domiciliary care to eligible veterans. Plans call for the construction of a 95-bed facility on the site of the former Hilo Hospital on the Hilo Medical Center campus. The cost estimate for the project is $31 million and VA is contributing 65 percent (i.e., $20 million) to compliment state funding. VA is excited about this project and looks forward to our continuing collaboration with Hawaii.

CONCLUSION

In summary, with the support of Senator Akaka and other Members of Congress, VA is providing an unprecedented level of health care services to veterans residing in Hawaii and the Pacific Region. VA now has state-of-the-art facilities and enhanced services in Honolulu, as well as robust staffing on the neighbor islands and has expanded or renovated clinics in many locations. VA is bringing more specialists

on board and preparing for the newest generation of veterans—those who bravely served in southwest Asia.

VAPIHCS still faces several challenges, in part due to the topography of its catchment area. VAPIHCS will meet these challenges by utilizing telehealth technologies, sharing specialists, developing new delivery models and opening new clinics as demographics suggest and resources allow. I am proud of the improvements in VA services in Hawaii, but recognize that our job is not done.

Again, Mr. Chairman and other Members of the Committee, mahalo nui loa for the opportunity to testify at this hearing. I would be delighted to address any questions you may have for me or other members of the panel.

Senator AKAKA. Thank you very much.

[Applause.]

Senator AKAKA. I have some questions for our witnesses. This first question is for each of our witnesses.

Based upon the feedback from post-deployment health assessment questionnaires and from what you have seen and heard, what kind of health trends are you beginning to see in the soldiers coming back from Iraq and Afghanistan? Some of these have been mentioned already by our witnesses. We're looking for all information we can get.

Another part of the question is: Are you seeing any indication of undiagnosed illnesses similar to the Gulf War Syndrome in servicemembers returning from Iraq and Afghanistan? And we'll take your responses in the order you were introduced.

General Osman.

General OSMAN. Senator Akaka, to answer the undiagnosed illnesses that we had seen come out of the first Iraq war, the Army Medical Surveillance Activity, which is headquartered in Fort Detrick, Maryland, is the agency that tracks that. At this point, they've seen no indication of undiagnosed illnesses coming out of Afghanistan or Iraq.

When we look at what we see in the Marines who are returning at this point, we have seen some indications, as we would expect, of combat stress. That is part of combat. It's a very natural part of combat. Probably some of the challenges we've had in the past is accepting that.

There's a tendency, of course, for military members kind of in a macho manner to try to look past that or ignore it and not accept the fact that combat stress is just another combat injury, much as would be a wound from a weapon that produces shrapnel. Accepting that, understanding that, allows us to address those combat stress issues early on.

We do that through our redeployment and post-deployment efforts. Because of those efforts, I really do believe we have seen probably a lesser number of combat stress-related incidents than we would have expected otherwise. Thank you, sir.

Senator AKAKA. Thank you.

General MIXON. Yes, sir. I would echo what General Osman has said in reference to the undiagnosed illnesses. We have not seen any. And the tracking system is very effective.

I can say just from my own experience—I'm a Gulf War veteran as well as a veteran of having served in Afghanistan, and I am registered in the Gulf War illness data base, if you will. I routinely get updates on what is going on in that system, and I am sure that as we document and provide updates on the current Global War on Terrorism, those that are registered will be provided accurate up-

dates. I'm comfortable to tell you that no, we have not seen anything like the Gulf War illness syndrome.

As far as health trends are concerned, other than those soldiers that we know are wounded and what their specific injuries are, we see common things such as orthopedic and what we might refer to as sports medicine type of injuries. The stress of combat, particularly on those soldiers that are involved in deliberate combat operations, we see similar injuries with them—knees, joints, backs, and so forth. And those are treated in a similar manner that you would treat a sports injury type of injury.

But the trend that we have to watch is exactly what General Osman said, is that of mental health problems. And these come in varying degrees. And we must be sensitive to those issues and provide the treatment. And at the present time, I believe we are taking the appropriate steps to do that.

We do so in two ways. First of all, the immediate screening that is done by the soldiers that re-deploy helps to try to identify those that may have been immediately affected. But I will tell you the soldiers, as they return, there is a euphoria of having returned. They're reunited with families. And a lot of times, the stress that they have undergone might be masked. It may be months later before it reappears.

The services have instituted a program of rescreening those soldiers about 3 to 6 months after they return to identify that period where they might be experiencing some stress, things such as sleep disorders, possible abuse of alcohol, drugs, and those kinds of activities.

So my point, Senator, is that it has to be a continual process. Combat is stressful no matter what you are doing. So we are sensitive to the issue of treating our soldiers for potential combat stress, both short-term and long-term effects that it might have.

General LEE. Senator, for the Hawaii Army National Guard, we've had aviation units come on back. And so far, we have not noticed anything similar, you know, unknown like the Gulf War Syndrome. We're keeping close tabs with our soldiers, with our family readiness, family support groups to keeping those intact such that sometimes they may be a little reluctant to maybe come forward, and we'll find out about that through the family support groups.

As General Mixon mentioned, the screening some time afterwards that we'll do during the drills. But now, with the larger Brigade Combat Team returning and certainly the units that have been in the thick of the action, we're going to look very closely at the results of the screening and perhaps, based on that, even recommend another rescreening maybe another 2 to 6 months down the line just to make sure we get a good trend.

Senator AKAKA. Thank you.

Colonel Horn.

Colonel HORN. Sir, we among our population have not seen any indication of any undiagnosed illness similar to Gulf War Syndrome. Among the soldiers that have returned so far, we've had more engineers come back than anything else. And I think, in addition to the sports type injuries that General Mixon referred to, I think we have some occupational workplace type injuries among

those soldiers that you would expect in the construction trades—some back injuries, legs, hands, that type of thing.

We also as the National Guard have a rigorous program of revisiting our soldiers with professionals, teams of professionals, periodically after their return and demobilization so that we provide the opportunity to make referrals and follow up on the self-assessments that come from the soldiers, input from our family readiness groups, and also, most importantly, input from the chain of command.

I think that a strong chain of command that knows their soldiers and is concerned for their welfare is our front line in dealing with emerging problems that may come up later. And so that's a major point of leadership within our organization.

Senator AKAKA. Let me say that Chairman Craig and I have been very concerned with the National Guard and Reservists because they are considered working people who were deployed, and concerned about when they return home and go back to work.

We ask active forces to go back to a base, and they go through some of these programs that are there for them. And we are very interested in seeing what can be done with the Reservists and National Guardsmen who come back to their families and go back to work.

And as all of you said, our military folks are macho. Many times they don't want to tell you they have a problem.

But some do, in fact, have a problem. As was mentioned here, it takes time before they finally admit it. But we need to help them as early as possible so that the problem doesn't get worse for each one of them. So I'm so glad to hear from you on this subject.

Dr. PERLIN. Thank you, Senator Akaka. Since the beginning of operations and the Global War on Terror, we've seen 119,247 servicemembers separated from all components, regular as well as all Reserve components. In fact, the electronic health record that we have really means that we can follow the health issues of each and every one of them and understand what are the top issues.

It's a generally younger population, and just as General Mixon said, the issues are not dissimilar from a younger population. Many of the musculoskeletal orthopedic issues are best characterized as sort of sports medicine type issues.

The other big category of issues are some dental health issues that we've been working with Department of Defense on. There is some difference between readiness for deployment and ultimate dental health, and we're working together on those issues.

We share the commitment that we screen, and are aware of any mental health issues as well, and are really appreciative to note that in the Department of Defense, this starts at the very front lines. There are combat stress teams forward deployed that include psychologists, and they don't wait for people to self-identify. If something happens on that day, bring the whole unit together and say, you know, what we saw today or what we experienced is very difficult, and we will talk about it. It's not—one doesn't have to self-identify.

We have much better information coming from the front. There are a number of programs that bring that health information forward. And of course, upon return, there's not only the separation

examination, but as these gentlemen mentioned, the post-deployment health reassessment, a systematic reevaluation of return servicemembers' health 90 to 180 days following deactivation or demobilization.

We have not seen anything akin to the undiagnosed illnesses as occurred after the Gulf War, and we feel very confident about these data, because as General Mixon indicated, he participated in a registry, which is something people had to actively sign up for.

In fact, for the veterans who receive care in VA, having all of their electronic health records means that we can follow each and every diagnosis and really look at what issues stand out—again, the sports medicine, the dental health, and being aware for mental health issues, including some totally normal symptoms after abnormal circumstances. And those are combat stress reactions that we neither want to overly medicalize, but we do, with shared outreach on support, want to be able to provide assistance for. Thanks.

General OSMAN. Senator Akaka, if I could have a follow-up?

Senator AKAKA. Please, General.

General OSMAN. Please, sir. I have two points I think would be important.

First, you raised an important issue, Senator, about the Reservists who come back from deployment, maybe a small bit of time with a unit and then they're back to their civilian job. How do we take care of those folks, particularly when we're looking at combat stress.

OSD has a managed health network that they've created. These are individuals who are experts in mental health addressing those problems. These are civilians. We're going to try to tie that network with our Reserve establishment.

Dr. Nash, who's the psychiatrist that heads up our combat operational stress program, is with our Marine Reserves right now trying to come up with a program that will allow these practitioners to actually call the Reservists at home after they've been demobilized, talk with them on the phone, things like sleepless problems, as General Mixon mentioned, problems with alcohol, relationships with their families, with friends, how things are going on the job.

An expert over the phone can begin to tell if maybe that individual could use some more help. So we're trying to address that issue that you raised because it is a very, very challenging one indeed.

I would like to add one other point, and that is there is a trend that we are seeing in this war that we haven't seen in previous ones, and it's probably not in line with what we would have thought. Today's battlefield is very mobile. It's incredibly lethal, and fortunately we have our doctors as forward deployed as possible.

We see soldiers and Marines that are sustaining combat injuries that in previous wars they would not have survived. But because we get them to medical care, to trauma centers very, very quickly, they survive. But they survive with some horrific injuries, ones that, again, you would not have survived in previous wars.

This is a challenge from several perspectives: one, to heal the broken body, but obviously, the mental health aspect in the future. And I know that our partners in the Veterans Administration, as

we hand off these very seriously injured and disabled individuals to the Veterans Affairs, are going to have a challenge that is really different from ones they've faced in the past. It's something we're going to have to pay very, very close attention to.

The great thing is the spirit of these wounded individuals is something to behold. Senator, I brought with me a picture of a young Marine who lost both of his legs above the knee. It's a picture of the young Marine back home in Colorado running around a track with a prosthetic device that we were able to provide.

Fortunately, the young Marine has the right kind of spirit you're looking for. He had a wonderful girlfriend. They've gotten married, and they're now going on with life. It's the ability to do that that's going to make a difference, particularly when it comes to the combat stress and the mental health aspect.

And I provide this picture of the young Marine running and he with his new bride because it tells an awfully, awfully good story, sir.

Senator AKAKA. Thank you very much, General. Thank you for your additional words on that. And you are correct, you know. This war is a little different. And our medical science is so good that they can keep people alive, but there are other kinds of problems that we've never faced before. And we need to certainly look at this.

And here's another problem I'm going to ask again for each of your responses. And this came about, too, 1 day after a hearing. Dr. Perlin, usually when we have high level hearings on veterans, Secretary Nicholson is there and so is Secretary Perlin. And after one of those hearings, we talked about PTSD.

And one thing he mentioned that stuck in my mind was that we need to be very careful about the records of these military people in terms of mental health issues and how they are reported. I understand that there are safety issues involved in the combat zones.

But if a servicemember did come forward with mental illness, for instance, issues, what kind of impact would this have on his or her career? So I'd like all of the witnesses to share whether or not you believe that there is a stigma attached to mental health problems.

General.

General OSMAN. Senator Akaka again has hit on a very important issue, and that is if you're going to address combat stress and mental health issues, you have to get past the stigma that we have unfortunately had to deal with for so many years.

Through our training efforts in pre-deployment, we really have tried to reach our leaders, our families, and each individual Marine that combat stress is going to be part of what they're going to experience, and that it's OK. Now, in a combat situation, if an individual should exhibit combat stress, again, treating it like any other kind of injury a Marine may encounter, we'll address it.

It may be something that is not serious at that time, and sometimes the buddy aid, talking things out, will allow the individual essentially to get past that and be able to continue to cope and perform, and it would have no impact at that time. It's possible that the individual may have more acute combat stress problems, in which case, much like if you had a more serious physical combat

injury, you may have to be taken out of the game in order to address it. And that's OK also.

I think the message is getting particularly to our leaders that combat stress is part of combat. The idea is to get them better so that we can get them back with their unit and get them back performing again. That's the goal. We have had many success stories, I'm proud to say, Senator Akaka, of individuals that did exhibit combat stress that got past it and have continued very successfully in their careers. Thank you, sir.

General MIXON. Senator Akaka, I think we all know, and I can testify without any doubt in my mind whatsoever, that there is no stigma attached to their career development once an individual receives assistance.

However, perception may be reality. And there is a perception down at the lower levels that if I go seek counseling and my chain of command learns about it, there may be some impact. And that's the challenge that we have. We have to remove that stigma.

Ladies and gentlemen, Senator Akaka, isn't it interesting that a person that's having trouble hitting a baseball can seek out a sports psychologist, and it can be all over the national media, and there's no stigma whatsoever. So we have to get to that level. And that's what we try to do through many of the programs that we run up at Schofield Barracks. And I'll just give you just a few examples.

First of all, we have, through a Government contract, contracted counselors that are down at the unit level. These are non-DoD personnel. They are male and female. And they work through the unit in a very informal manner. They're very low threat, if you will. And they get to know members of the unit, and they talk to members of the unit in the dining halls and the unit areas.

And if they identify problems like General Osman just mentioned, they encourage the soldier to go to the professional counseling. But these particular people keep no records. They do not report these things unless they see some serious threat to that individual's life. This is a program we're trying at Schofield, and we think it's being very successful. That's one program.

The other program is the education of those soldiers' families prior to deployment. The wives will attend what we call, you know, re-engagement sessions: How are you going to re-engage with your husband, your spouse, when they return from the combat zone? And what are some of the signs that you may look for that there are stress problems? And what are the agencies on Schofield Barracks and other places where you can seek help for your spouse? So educating the full family team is important.

In addition to that, we continue to run marriage enrichment programs at Schofield Barracks so that 3 and 6 months afterwards, those families that are deployed go to marriage enrichment programs, weekend retreats, if you will, so they can reconnect and possibly identify problems. We have identified cases where the servicemember has held back until they go to these particular sessions in an offsite, in a very low threat environment.

And I would mention one last thing. The experience that our Vietnam veterans had and are experiencing now years after the end of the Vietnam conflict is important. We have connected many of today's veterans with the Vietnam veterans that are in the local

veterans organizations in and around Schofield Barracks. Specifically, we brought an individual to the Schofield Barracks area named Mr. Dave Riever [ph].

Mr Dave Riever was a Navy person who operated on the rivers of the Mekong Delta who was seriously burned and disfigured in a combat accident. He is a motivational speaker that shares his experiences of how he recovered and how that process—and how he went through that, and the mental anguish that he experienced over the years.

We brought Mr. Riever to Schofield Barracks. He spoke to many of our combat veterans and almost to every soldier on Schofield Barracks about his experience. The outcome of that was some soldiers seeking assistance because they now identified with another veteran who over a period of years has dealt with the challenges of the injuries that he sustained.

So we take a multi-faceted approach, is my point, Senator. We'll stay tuned in to what's going on and do the best we can. But once again, my up-front statement: No stigma to their career development. The challenge is getting them to seek assistance when they need it. Thank you, sir.

Senator AKAKA. General Lee.

General LEE. Senator, in the Reserve components, I guess the division between the Guard and the Reserve, you have most of the combat units being in the Guard, and with the one exception that we're real happy to have the 100th Battalion, 442nd Infantry, as part of the 29th Brigade.

And as such, you know, we are very concerned about the mental health side. And like General Mixon says, we have this ingrained perception to overcome where if you have a physical wound and the bandages are gone, you know, it is equal to recovery. But from the mental state, it's difficult to really determine the start and the end.

And I think we've just got to set by example so that the soldiers know that, you know, by example, by actions, they're still eligible for promotions. It's not going to encumber their career. And it's just going to take some time for the word to get on out that says, hey, this is OK. We really need to help you. Come and talk to us, even in a discreet manner.

So sir, for the 29th Brigade Combat Team, as an extra, we mobilized our trained mental health counselor. She was head of our family readiness program, but I said, hey, this is even more important. You go ahead and mobilize with the brigade, that as a trained mental health counselor, her discussions with me before the unit departed for Iraq is, hey, I know how to talk to the local guys, you know? I can connect with them.

And so what I'm trying to do right now is to continue her service in active duty because she has her list of clients that she has seen in country, from California to the brigade, the rest of the units in the brigade, American Samoa and Saipan, that she has spoken with me that she would really—she kind of knows who needs the extra help and are reluctant to come forward.

And I'm trying to keep her on active duty to provide this continuity of service for however long it takes, months or years down the line to—because they've earned her trust in the combat zone, talking to her. And in many cases, it's just talking to someone that

understands. She's certainly been there with them, and I think we'll be successful in keeping her on active duty to continue this engagement with our soldiers of the brigade.

Senator AKAKA. Thank you.

Colonel.

Colonel HORN. Sir, our organization spans many different cultures, from small Indian villages in Alaska all the way out to the Manu'a Islands in American Samoa. Unfortunately, I think across all of those cultures, there is still a stigma associated with mental health issues.

Our challenge is, again, as with all of our organizations, to break through that stigma and make sure that our soldiers understand that there will be no repercussions, no harm to their careers, from coming forward or seeking assistance.

Again, I think, as for all of us, the challenge is in educating our soldiers that there is no stigma. We've incorporated that effort into our institutional training in the Army, into our specific training in preparations for deployments. As with the active component, we incorporate our families in that training.

There's pre-deployment training for the families. Shortly before our soldiers return, there's reintegration training. And part of that is, as with the active component, using many of the same resources here in the Pacific to educate the families to be on the looking to be helpful, to bring issues forward.

It's a multi-disciplinary effort. Again, our chaplains have been a tremendous help in this process. Substance abuse counselors. Legal people. Often these problems manifest themselves in other dimensions—domestic abuse, substance abuse, legal problems.

We have had a few cases—just yesterday I was speaking to our command chaplain about a soldier from Samoa that's here on Oahu now receiving help at Tripler. So we have a support network in place to help these soldiers. The problem is getting out there identifying them and getting the appropriate help at the earliest possible time, and helping them with their career, and retaining them as soldiers.

Senator AKAKA. There's no question that the cultural values and aspects are really becoming noticeable, and particularly in Hawaii. We're such a diverse State and we have many ethnic groups here. This is also true throughout the country. I'm so glad to hear that we're focusing on this as well to help our military people heal well.

Dr. Perlin, do you have any comments to make on this?

Dr. PERLIN. Thank you, Senator Akaka. Regrettably, I do think we have to acknowledge that in the world, there still are stigmas associated with mental health issues. I think, though, behind your question, there are really two issues. One, how do we get people the care they need? At the same time, how do we avoid overly labeling individuals in ways that may be limiting, not only in terms of—and even if not especially outside of the military, in their own career development, but in terms of their own definitions.

Yesterday, we were honored to have you lead off the stress, violence, and trauma conference on Oahu. Thank you very, very much for that. So much of the theme there was, how do we change to make sure that we build on the person's strengths and build on their inner resilience so that they can be as functional as possible

and recover as much as possible, and define their lives not in terms of illness but in terms of recovery, not in terms of disability but in terms of possibility. I think that's so important.

Yet at the same time, I think we acknowledge that there are history where it's been difficult to identify, and from the forward deployment of combat stress teams to the very novel and proactive and absolutely contemporary approaches that Department of Defense is using today, to when an individual separates, the post-deployment health reassessments, to VA's outreach.

Secretary Nicholson has sent 433,398 letters to separating servicemembers from the Global War on Terror identifying that there are resources there, and again, emphasizing recovery and function without overly medicalizing or putting labels on, pathologizing. It's really something that we hope to effect through our Global War on Terror outreach counselors, coordinators at our Vet Centers.

We met on Wednesday at Oahu, at the hearing on Oahu, Matthew Handel [ph], himself a veteran of OIF, who was there to provide that sort of non-medicalizing support for stress reactions that may be in fact a very normal part of the experience. Again, not PTSD. When symptoms are severe or intrusive, then we get into a more intensive sort of treatment.

Again, the ability to outreach by people who have been there. And it's my pleasure, if I might be somewhat unorthodox, and introduce Mr. J.L. Sisto [ph], Army Reserve, who is in fact part of the VA Pacific Islands Health Care System. Jay, would you—in the purple lei there—and provides that sort of outreach without medicalizing, helping people to identify issues and anxieties, deal with them, and where more intensive issues exist, to refer those for appropriate and greater depth of therapy.

Senator AKAKA. Dr. Perlin, the VA clinic in Kona on this island is bursting at its seams. This is widely known. My question to you is: Are there plans to do anything to expand their space?

Dr. PERLIN. Yes. I've been—thank you, Senator Akaka, for that question. Let me ask Dr. Steve MacBride, our chief of staff for the VA Pacific Islands Health Care System, to describe some of the plans to augment services there at Kona.

Dr. MACBRIDE. Thank you, Dr. Perlin.

Welina, Senator Akaka.

Senator AKAKA. Welina.

Dr. MACBRIDE. I'd like to just take the opportunity very quickly before I answer the question to bring you greetings from the clinical staff of VA here in Hawaii. We all have been working to prepare for the hearings, but we wanted to let you know how much we appreciate you, Sir. And it's always a delight when you come to visit us. We salute your caring for veterans, and we very, very much appreciate your personal caring for us as individuals. And it seems very appropriate that the fourth hearing here is on the Big Island, the home of the greatest Hawaiian warrior, Kamehameha the Great.

We are very pleased to announce that we will be relocating the Kona CBOC. We have found new space, and a brand-new building is being constructed. VA is going to be relocating in order to provide that additional space, and with that we're able to bring new

telemedicine equipment that we did not have at the former CBOC in the amount that we will be able to have.

As well, all of our CBOCs have the automatic drug dispensing MCS, which allow veterans to receive their prescriptions right there in the clinic, dispensed remotely from our pharmacy in Honolulu. We weren't able to do that in Kona because of space considerations, and now that will be possible.

We expect to be opening the new clinic by mid-year of 2006.

Senator AKAKA. Good news. Thank you very much.

Dr. Perlin, I know we discussed this a bit at the hearing in Maui. But I'd like to again address the relocation of the clinic. It is my understanding that there will be outpatient services put in place on the Big Island to ensure that veterans can get mental health treatment if the need it.

But how will inpatient psychiatric needs be met here in Hilo? And of course, we're interested in when will the new Hilo mental health clinic be up and running?

Dr. PERLIN. Well, thank you, Senator, for that very important question. I was very much assured this morning when I visited the Hilo CBOC to find and meet Dr. Andrew Bissett [ph], who is the psychiatrist, and Gordon Schrader [ph], who's actually sitting here in the second row, one of the very few certified addiction specialists here in Hawaii. And they are in location in the Hilo CBOC.

In fact, the PTSD Residential Rehabilitation Program has always been just that, a residential rehabilitation program, not inpatient psychiatry. Our Hilo CBOC is located across the street from the Hilo Medical Center, which has attached to it an inpatient psychiatric unit. Of course, that unit is available in emergencies, and that will not be dissimilar from what's existed in the past, the emergency use of that.

We of course have our inpatient psychiatry at Tripler. I was absolutely pleased to see that the new venue for the PTSD Residential Rehabilitation Program on the Tripler campus is in an area that actually exists above the office of the commanding general's—well, actually, the commanding general's lanai. Anyone who might have been on that lanai knows that it's absolutely panoramic.

This is one floor, one or two floors up. It's 5C1. And in fact, if you look out to the right, you see Pearl Harbor. To the left is Diamond Head. So, there is suitable space for this unit to relocate, and they're in the process of relocating that there.

So increased mental health support at the CBOC, with the new substance abuse program based here with certified addiction specialists, a continuing relationship with Hilo Medical Center's inpatient unit, and of course, our inpatient unit at Tripler. And a really very nice venue over at 5C1 in Tripler.

Senator AKAKA. Thank you very much, Dr. Perlin. Let me further ask, are efforts being made to find employment for the PRRP employees who were displaced in Hilo?

Dr. PERLIN. Well, as I mentioned, I'm pleased that Dr. Bissett and Mr. Schrader are going continuing to be part of the staff. I'm going to ask Dr. Wiebe to elaborate on where people are relocating.

Dr. WIEBE. Thank you, Dr. Perlin.

As Dr. Perlin noted a moment ago, we are relocating the center from Hilo to Honolulu. And there were several reasons why we

made that decision. One of them has been the difficulty of recruiting staff here in Hilo at the PRRP, and that's resulted in some lower class sizes over the years.

But the major reason for relocating the PRRP is to better serve our veterans. As we have talked about it today, there will be a large number of our newer veterans coming into the VA system, and our way of approaching their needs, whether it be an acute adjustment disorder or full-fledged PTSD needs, to change as well.

The 16-bed unit will be, in its entirety, relocated to Tripler, as Dr. Perlin noted. But in addition, at that location, we will also institute an intensive outpatient program to serve our newer veterans, who often come with families, with jobs, and are not able or willing to spent the 6 to 10 weeks in the PRRP, and would instead benefit from an outpatient program that would be similar to a PTSD day treatment program.

For the employees that were employed here at the PRRP, we have offered every employee the opportunity to transition with the center to Honolulu, and VA would pay for the relocation expenses. It's my understanding that several employees have accepted that and are choosing to do just that.

In addition, as Dr. Perlin noted, we are enhancing our outpatient mental health services here in Hilo, and several employees—again, including Dr. Bissett and Mr. Schrader—are working now already at the CBOC. For the remainder of the employees, we will need to continue to talk with them and with their union representatives.

My first position in the VA system was as an emergency room physician at the Martinez VA Medical Center, and approximately 5 years into my VA career, a decision was made to close that facility in Martinez, California because of concerns about damage to the building from a major earthquake.

So I personally know some of the concerns and some of the disruption that such a change can occur. And I can assure all the employees and all of their families and all of their friends that we are very aware of that, and we will work very closely with each individual employee to come up with the best possible solution.

Again, some of them hopefully will continue to relocate to Honolulu. Some will remain here in Hilo. And again, on an individual basis, we'll work with each employees to hopefully come up with a solution. Thank you.

Senator AKAKA. Thank you very much. We're talking about families and the importance families have in what we're trying to do. Programs such as the New Hampshire National Guard's Reunion and Re-entry Program place importance on the inclusion of family members of returning soldiers and military folks, and the transition process.

Dr. Perlin, how can this type of transition program be duplicated in Hawaii, and how could VA collaborate with the Department of Defense to ensure that this program can be established?

Dr. PERLIN. Thank you, Senator, for this important question. The transition program is inadequate if it doesn't really accommodate spouses and other family members in assuring that there is a continuity of information.

I want to thank our colleagues from Department of Defense for participation at every level, from the unit commands to Adjutant

General's office and to National leadership who have helped really create unprecedented partnerships.

Let me just note what has happened in New Hampshire as an example of the sort of collaboration. It may be a little forward of the rest of the country, but something that we would hope to do here in Hawaii and throughout. It's absolutely a model.

The program, these programs, the Reunion and Re-entry or similar programs, involve really a collaboration between all elements of VA, not just our Veterans Health Administration, but our sister agency, the Veterans Benefits Administration, and colleagues from Department of Defense and representatives of State Departments of Veterans Affairs, in meeting and greeting returning servicemembers.

Basically, in the past, what's happened is that people who were demobilizing have been greeted with an onslaught of information. And if one line says, you know, sign up for additional screenings, additional conferences, et cetera, et cetera, et cetera, and you've been on a tour for 6, 12, 18 months, and the other line says, go home, you're going home. You're not going to go to line A, as much as we would hope that people would get that information.

So this program really involves all of these elements coming together from Veterans Health, Veterans Benefits, DoD, State, et cetera. But when the servicemember returns home, they're given 24 to 72 hours of leave to decompress and reacquaint with family, and then come back with family members, family members who also can hear some of the information that's provided.

That information extends from outreach coordinators, such as J.L. Sisto and his colleague in the Vet Centers; Matthew Handel here in Hawaii, greeting those returning troops and first identifying that it's OK, it is not improper, to identify that you might have a need.

It's providing information such as the more than a million and a half of these brochures that provide a summary of benefits—this one for Reserve; there's a similar one for separating active duty servicemembers. CDs and little pocket CDs and wallet cards and all sorts of information that really helps to make a very positive approach. Information from Veterans Benefits about loans for housing, about the G.I. Bill benefits for education. Things that the individual may not have themselves thought about in terms of next steps. Things perhaps that their spouse may have thought about in a great deal of detail, or wants to attend to in terms of thinking about relocations or further educational opportunities.

And so it really is very much a family activity. It's very much an interdepartmental activity. It involves the highest levels of our departments, at our Secretary's level—the Commandant of the Marine Corps has—I've met with, with Secretary Nicholson, and appreciate, as an example, that degree of relationship and the seamless transition there—to the very front line, the garrison commands who support these programs with all elements involving spouse and family members.

And we will continue to push forward in these sorts of activities to make sure that the transition back to civilian life is as effective and well-supported as possible. We look forward to working in particular with General Lee and the State of Hawaii, and General

Mixon and Colonel Horn and colleagues in terms of anything we might do here in collaboration with our Vet Centers and with our health system.

Senator AKAKA. Thank you very much, Dr. Perlin. I am so grateful for the responses we've heard this morning here. And I want to say mahalo nui loa, to our military leaders in our country. I'm Ranking on Readiness Subcommittee and on Armed Services. We have the best military leaders around. I've been with the Department of Defense.

So when I say this, I really mean it, that we have the best military leaders in the world, and some of them are here today. We are so fortunate in our country because they've ensured our liberty and freedom that we enjoy today.

Also, I'm so delighted to have the leaders of our VA, both nationally and locally, who are here to witness and give their testimony. And we've heard from them. So you've heard the best advice you can get, the best information, and I'm really grateful. And I want to say mahalo nui loa to all of you for being here this morning and for making these four sessions, hearings, on Veterans' Affairs the best. No ka oi ichiban.

So thank you very much, all of you. And I'll call up the second panel in a moment. Thank you very much.

[Recess.]

Senator AKAKA. The hearing will come to order.

At this time I'd like to introduce our second panel. Jon Harlan, M.S.W., Team Leader, Hilo Veterans Center; Kevin Kunz, M.D., President, American Society of Addiction Medicine; Sergeant Greg Lum Ho, Army National Guard; and a veteran, Katherine King.

So we're glad to have all of you this morning. We look forward to your testimony. And we will give our testimony in the order in which I introduced you.

John Harlan.

STATEMENT OF JON HARLAN, M.S.W., TEAM LEADER, HILO VET CENTER

Mr. HARLAN. Aloha, Senator Akaka. It is an honor to appear before you today, especially due to your long and continued support for Vet Centers in our Nation, and knowing that you are the father of the Vet Centers in Hawaii. Over the years, your continued support for our Vet Centers and our existence has been noted and appreciated. So I thank you for that, first of all.

Today I want to outline the role the Hilo Vet Center has in providing care and services to veterans of all eras, with special emphasis on newly returning veterans from Operation Enduring Freedom and Operation Iraqi Freedom. Although I will focus on the Vet Center's involvement, our efforts are typical of the 207 Vet Centers across our Nation.

Under the leadership of Dr. Alfonso Batres, Chief of the RCS, and Mr. Richard Talbott, the Western Pacific Regional Manager, the Hilo Vet Center, located in old downtown Hilo, strives to provide the highest quality of care and services to veterans who walk through our doors and those we meet through our outreach efforts. It is a privilege and honor to serve them.

The Hilo Vet Center is responsible for providing services to veterans from the southern end of the Big Island, Naalehu, to the far west side town of Waimea. Services provided by our Vet Center include individual, family, and group counseling, with a special emphasis and expertise in counseling for combat-related post-traumatic stress disorder.

We also emphasize community outreach and assistance in gaining access and working with our brethren in the VA medical community, CBOC. We also provide onsite assistance with the VBA staff, who come to our Vet Center once a month to assist veterans with their claims. We also work closely with the State of Hawaii Veterans Service Officer, Mr. Keith Rivencho [ph], who helps us with veterans in filing of their claims. And we conduct joint outreach services with him. He is a partner of our Vet Center in every way.

Concerning specifically the returning veterans and our concern there is in the Hilo area, we have many Guard and Reserve units. One is Army National Guard 2nd Battalion, 299th Infantry, which, as was described to you earlier, is currently returning to Hawaii and was definitely in the thick of combat.

We also have the Army Aviation, Army National Guard 193rd Aviation Regiment, and the Army Reserves 411th Combat Engineers. In addition, there is a section of the Reserves' storied 100th Battalion, 442, that's co-located with the 411th Combat Engineers.

The Kona Vet Center covers the remainder of the Big Island, providing services to all eligible veterans, which includes one company of the Hawaii Army National Guard 2nd Battalion, 299th Infantry, which is located in Kealakekua, Kona. As a member of the Hawaii National Guard, as well as being the Hilo Vet Center Team Leader, I have personally made frequent contact with members of these units and their families to provide them with information about Vet Centers and VA services, and to support family members during the time of deployment.

The staff of the Hilo Vet Center was prepared and given the additional mission of providing bereavement counseling for family members of military personnel killed on active duty in Iraq or Afghanistan. Sadly, we have on this island suffered the loss of one fine young American from the Volcano area, and I made contact and offered support to his family.

We hope and pray that all of our service men and women will return home safely soon, as most of them, their deployments are more than halfway over. Most of them are on their way home. But guarantee you for that family in Volcano who lost their son, their life will never be the same again.

The Hilo Vet Center tries to maintain nontraditional hours to ensure services are available to all veterans, both those that work and those who don't. We are currently open Mondays and Tuesdays from 8 till 6:30 p.m., and Thursdays from 8 in the morning to 8 in the evening. We expect to increase substantially evening hours as more soldiers, especially the Guard soldiers, return home and return to work, and their need for services will be in the evenings and possibly on weekends, as they will not want to interfere with their work schedules because that issue we talked about of stigma.

Although we want to say maybe it's not there, it is still there. And many soldiers I've talked to don't want their employers yet to know that they are, you know, coming to a place like the Vet Center.

We strive to support these units and these veterans' organizations by providing outreach and informational presentations whenever they are requested. We believe by doing this and always being available, veterans who otherwise may never come to the VA will come and get the care and help they have earned.

During the time the units have been deployed, we have worked numerous times with family support groups to inform them about the Vet Centers and the type of services we offer, and urging them to be ready for their husbands or wives when they return, and kind of what kind of things to expect.

I believe this has paid dividends in the fact that on Monday, we received a call from a soldier in Kuwait, who was calling before he even left Kuwait to set up an appointment to come see us upon his return because, somehow, he's already been given the information about a Vet Center and he is going to be seen very soon upon his return home.

The Vet Center has a core staff of three people: a Team Leader—myself, one counselor, and an office manager. Currently we are happily in the process of hiring a full-time Global War on Terrorism outreach worker that is currently in the Honolulu VA personal office. We hope to have that person on board. It's a female soldier who is a recent veteran of OIF herself.

Her responsibility will be stationed at the Hilo Vet Center, but she will be responsible to cover the entire island, to include the Kona side. And the Kona and Hilo Vet Center work very closely together. Felipe Salas [ph] is my fellow Team Leader. He was back here somewhere.

The other thing about the Vet Center is all of our staff are veterans. One member holds licensure. Two of them are Vietnam veterans. The other two of us are Gulf War veterans. We have—due to our small permanent staff—we augment ourself for clerical support with the VA Work Study Program, which helps young veterans attend college, earn a salary while helping other veterans, and provides for a smooth operation of our small Vet Center.

Having them has been a godsend, not only for the additional work they do, but more importantly, because usually they are veterans themselves of OIF/OEF operations and have been able to give us, who haven't been there, key insights into understanding the unique experiences and needs of their peers in the current conflict.

All of our Work Studies have been outstanding and show a great deal of compassion for their fellow veterans who come in or are contacted as they assist us with outreach. I believe this program could be very valuable in recruiting future professional staff for our Vet Centers, as most of us in Vet Centers are reaching very near retirement age.

The Hilo Vet Center continues to provide readjustment counseling and supportive services also to a large number of Vietnam veterans, as well as veterans of World War II, Korea, and other conflicts such as Somalia. During fiscal year 2005, the Hilo Vet

Center provided services to 731 individual veterans in 5,800 sessions, and to family members.

During this same period, we began to see an increasing number of OEF/OIF veterans and their families. In fiscal year 2005, we saw 51 veterans of these new conflicts for 118 visits, compared with only 4 for the year 2004. Our expectation and concern is that when the largest deployed unit from this island, the 2nd Battalion, 299th Infantry, returns to Hilo, we will be seeing far more OEF/OIF veterans because they were in heavy combat situations. We would naturally expect their degree of acute stress, stress reactions, would be higher than the units that have already returned.

Our Vet Center strives to provide intense and complete counseling for veterans on the east side of the Hawaii island. Our goal is to assist veterans in leading productive—sorry, Senator, this is nerve-wracking, in an way—and satisfying lives. As stated earlier, we do this by providing individual, family, and group counseling. And again, as mentioned earlier, involvement of the family is key.

The families are already concerned, even before their soldiers have returned, about what the soldier is going to be like, whether male or female spouse. And they want to know what services are going to be available for them and their families. In the past, family services were lacking. So I am hoping that it is an area that we will be able to increase in order to achieve the goals of preventing post-traumatic stress disorder and keeping it as a readjustment issue.

Our intent is to extensive outreach to these units. In other words, the National Guard units that have returned, we have attended all of their welcoming ceremonies and set up a table with numbers and mainly that they see the face, that, you know, here we are. We want to help you. Come see us. I think that when you're there, you know, in the welcoming ceremonies, it pays great dividends later on because you've established a comfort level with them. That is one way I met Sergeant Lum Ho, was when his unit had a welcoming ceremony and I spoke to him and decided he would be a great witness for his fellow vets.

Our challenges as we do this is to continue to provide high quality care to our core constituency of World War II, Korean, and Vietnam veterans. I consider it a great honor to provide services to multiple generations of America's finest. I believe it's the greatest job in the world, and I want to thank Senator Akaka and your Committee for providing the support for allowing our Vet Centers to exist.

Senator Akaka, this concludes my statement. I thank you for your time and your efforts on behalf of our State's veterans and our Nation's veterans, and look forward to answering anything questions you or your Committee may have. Thank you, sir.

[The prepared statement of Mr. Harlan follows:]

PREPARED STATEMENT OF JON HARLAN, M.S.W., TEAM LEADER, HILO VET CENTER

Aloha, Senator Akaka. It is an honor to appear before you today to outline the role of the Hilo Vet Center in providing care and services to veterans of all eras, with special emphasis on newly returning veterans from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). Although I will focus on the Hilo Vet Center's involvement, our efforts are typical of the services provided by the 207 Vet Centers nationwide.

Under the leadership of Dr. Alfonso Batres, Chief of the Office of Readjustment Counseling Service, and Mr. Richard Talbott, the Pacific Western Regional Manager; the Hilo Vet Center, located in old downtown Hilo, strives to provide the highest quality of services to all Veterans who walk through our doors and those we meet through our outreach efforts. It is a privilege and honor to serve them.

The Hilo Vet Center is responsible for providing services for veterans from the southern end of the Big Island, (Naalehu) to the far west side town of Waimea. Services provided by the Hilo Vet Center include individual, family and group counseling, with special expertise in counseling for combat-related Post Traumatic Stress Disorder; community outreach; assistance in gaining access to medical care through the Hilo VA Community Based Outpatient Clinic (CBOC); and onsite assistance for veterans with VA disability claim issues by a VA Benefits Counselor once a month. We work closely with the State of Veterans Service Officer, referring veterans to the VSO for in-depth service on claims issues; we also conduct joint outreach efforts with the VSO in the Hilo Vet Center's catchment areas.

In the Hilo area we have one National Guard Unit: the 2nd BN, 299th Infantry BN, Army Aviation Units (193rd AVN RGT), and the Army Reserves 411th Combat Engineers, in addition to a section of the Reserves' storied 100th, 442nd Infantry. The Kona Vet Center covers the remainder of the Big Island, providing services to all eligible veterans, which includes a company of the Hawaii Army National Guard 2nd BN, 299th Infantry BN located in Kealekekua, Kona. As a member of the Hawaii Army National Guard as well as being the Hilo Vet Center Team Leader, I have personally made frequent contact with the members of these units and their families to provide them with information about Vet Center and VA services, and to support family members during the time of deployment.

The staff of the Hilo Vet Center is prepared to provide bereavement counseling for family members of military personnel killed on active duty in Iraq or Afghanistan. Sadly we have suffered the loss of a fine young American from the Volcano area, and the Vet Center offered support to his family. We hope and pray that all our servicemen and women will return safely very soon, as their deployments are more than half-way over.

The Hilo Vet Center maintains non-traditional hours to ensure that all services are available to veterans, both those that work and those who don't. Currently we are open Monday and Tuesday from 8 am to 6:30 pm and Thursdays 8 am to 8 pm. We expect to provide additional evening hours as more soldiers return home and to work and need or want more services. We strive always to support military units and veterans' service organizations by providing outreach and informational presentations whenever they are requested. We believe by doing this and always "being available," veterans who otherwise may never come to the VA will get all the care and help that they have earned.

The Hilo Vet Center has a core staff of three: Team Leader, one counselor and an Office Manager. Currently we are in the process of hiring a full time Global War on Terrorism (GWOT) Outreach Worker. This person will be stationed at the Hilo Vet Center, but will cover the entire Island, to include the Kona side. The Kona Vet Center and Hilo Vet Center staff work together closely on outreach each week, so this arrangement will work well. All Team Members are veterans. One member holds mental health licensure (Social Work); and the others have many years of experience working with Veterans, especially in the area of combat-related trauma. The Hilo Vet Center, due to its small permanent staff, has augmented clerical support staff for several years through the VA Work Study Program, which helps young veterans attending college earn a salary while assisting other veterans and helps provide for the smooth operation of the Hilo Vet Center. Having them has been a Godsend, not only for the additional work they do, but more importantly, because they are usually veterans of the OEF/OIF operations and give staff key insights into understanding what the unique experiences and needs of their peers in current conflicts. All of our Work Study students have been outstanding and show a great deal of compassion for their fellow Veterans who come in or are contacted during outreach. I believe this program could prove to be valuable in recruiting future professional staff for our Vet Centers.

The Hilo Vet Center continues to provide Readjustment Counseling and supportive services to a large number of Vietnam Veterans, as well as veterans of World War II, Korea, the current conflicts and others. During fiscal years 2004 and 2005, the Hilo Vet Center provided services to 731 individual veterans in 5,894 readjustment counseling visits for veterans and their family members. During the same time period we began to see increasing numbers of OEF/OIF Veterans and their families. In fiscal year 2005, we saw 51 individual OIF/OEF veterans for 118 visits, compared to just 4 OIF/OEF veterans for 17 visits in fiscal year 2004. Our expectation is that when the largest deployed unit (2nd BN, 299th Inf.) returns to

Hilo, we will be seeing far more OEF/OIF veterans. Our Vet Center provides intense and complete counseling for veterans of the east side of Hawaii Island. Our goal is to assist veterans in leading productive and satisfying lives. As stated earlier, we do this by offering veterans individual, family, and group counseling. To achieve our goals and meet the full range of needs for the veteran and family members, many of our veterans are involved in all three modes of counseling. In regards to OEF/OIF Veterans, our intent in offering extensive outreach to them is to let them know of our presence, to introduce them to the services that we provide, and to give them a sampling of the range of readjustment counseling services available to help them make a positive return to civilian life, as well as to assist their families. At the same time, we continue to provide the same high quality readjustment assistance to our core constituency of World War II, Korean War, and Vietnam veterans. It is a great honor to provide services to multiple generations of "America's Finest". I believe I have the greatest job in the world, and I thank you and your colleagues for providing the support to allow our Vet Centers to exist.

Senator Akaka, this concludes my statement. I thank you for your time and look forward to answering any questions you or other Members of the Committee might have.

Senator AKAKA. Thank you for your testimony.

[Applause.]

Senator AKAKA. Dr. Kunz.

STATEMENT OF KEVIN KUNZ, M.D., M.P.H., FASAM, PAST PRESIDENT, HAWAII SOCIETY OF ADDICTION MEDICINE

Dr. KUNZ. Senator, thank you for the opportunity to come before you today to offer these comments regarding the treatment of Hawaii's veterans who have PTSD and drug-related problems. Also mahalo for all of you, aloha to our veterans in Hawaii and for your activity in the treatment of drug addiction both in Hawaii and across the country.

The Hawaii Society of Addiction Medicine is an organization of 26 physicians, a chapter of the American Society of Addiction Medicine with 3,000 physicians. Our organization is dedicated to improving the treatment of alcoholism and other addictions, educating physicians, promoting research and prevention, and enlightening and informing the medical community and the public about these issues. Our members practice in all aspects of medical care in this community and nationally, from research to positions in clinics and in the VA.

We wish to immediately 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 Vietnam veteran and have personally received services from Hawaii's VA programs.

The association of combat service, post-traumatic stress disorder, and substance abuse is well-known. Perhaps the most poignant lessons from our old wars has been these: (1) PTSD and its comorbidities are predictable, preventable, and treatable; (2) The co-

occurrence of PTSD and substance abuse is the norm, not the exception. As we know in all aspects of civilian and military life in any setting, violence is the superhighway to addiction; and (3) PTSD can be successfully treated only to the extent that co-existing substance abuse is treated.

The problems of PTSD, addiction, and dysfunctional lives will only grow as more vets return. We should never use the term "normal" in explaining PTSD. That is denial and perpetuates the stigma of the disease. And with PTSD and addiction—unique in medicine—the worse someone gets, the less likely they are to ask for help.

Our 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 summarize seven specific problems and make recommendations for Hawaii's programs, with particular attention to the outer islands, where resources for the treatment of substance abusing veterans are woefully inadequate.

(1) Substance Abuse Counselors: On the outer islands, the VA Community-Based Clinics are all lacking a certified substance abuse counselor. If the vet has a significant alcohol or drug problem, he will need to obtain specialized services, perhaps medical detoxification or intensive outpatient treatment. It's not enough to suggest they go to AA or NA. Many vets are too sick for that. Ten years ago, there was a CSAC rotating between Hilo and Kona. Now we have none. We recommend that what's been spoken of here today be put in place, where we have certified substance abuse counselors at each clinic.

(2) The 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: pain pills. And non-opium, non-heroin opiate prescription drugs are readily available.

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. 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. Five years ago, Congress passed the Drug Abuse Treatment Act of 2000, which made available the medication buprinorphine for the treatment of opiate dependence.

Unlike methadone, buprinorphine can be prescribed by physicians outside of the classic methadone clinics. It has less risk of diversion and abuse, and a much better safety profile. Methadone is currently associated with emergency room deaths from overdose.

Although thousands of physicians are successfully prescribing this medication across the country, the VA has been slow to integrate its use. It needs to be an option within the VA system. It is available in Los Angeles and about 10 other States, but not Ha-

waii. 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 patients.

(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. 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 until the VA itself can establish these facilities, it can contract with existing programs that meet every other State and National certification.

(4) A brief comment on the Hilo PRRP: The benefit of that program on the Big Island was not limited to the vets who participated there. The staff was available to other healthcare 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 and drug co-morbidities.

Your announcement, Senator, 2 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 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 neighbor islands, on other neighbor islands.

(5) Prevention Services: Although some veterans from the current war are trickling in, as Mr. Harlan said, we expect that it will be 5, 10 years or longer before most vets with PTSD and related substance abuse problems ask for help. Yes, some of them will be seen at emergency rooms, jails, 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, as has been spoken of here today, are trying pre-emptively to deal with this by educating personnel, et cetera. 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. PTSD and addictions are family and community disease, as well, diseases of the individual who has it. When we consider the 3 to 400 National Guard soldiers who are expected to return to the Big Island this year, we know that we need to gear up new types of services. We recommend a new set of outreach services.

Two final things. First—

(6) Training for 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 are the best. There is a combined addiction medicine/ psychiatry residency available in Hawaii. We

are lucky to have it. It's a good program, well run. It is run through the University of Hawaii's School of Medicine.

The Spark Matsunaga VA Medical Center is currently lacking a postgraduate, year-5 position in addiction medicine/psychiatry. Such a physician could rotate inter-island and educate and support physicians in the VA and in private practice in the care of vets. This position would support and compliment the expansion of services that have been talked about.

(7) Finally, Community Cooperation: VA physicians, including psychiatrists, often do not participate as equal members of the medical community. At least on the outer islands, they do not routinely share hospital work, including on-call, with other physicians.

There are two down sides to this. First, it sets up the veterans and the VA physicians as being apart from, rather than a part of, the community healthcare resource network. Second, when a vet who is receiving care from the VA needs hospital admission, he or she can be perceived as being "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 local medical societies, and that they maintain at least a courtesy staff status at hospitals.

I will now talk about the statistics of how we've seen people increase in the VA system for PTSD, a 42 percent increase and other details over 5 years, most of whom have been Vietnam vets, not vets of the current war.

We are now funding wars in two countries, increasing the probability that there will be more men and women with war injuries, including PTSD, alcoholism, drug addiction. There is a perception that services aren't being matched and that 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 broken lives of gallant veterans and their blameless children?

We recommend, Senator, that you continue your efforts, that America match its commitment to the war with the resources for our warriors when they return home. Thank you for allowing me to offer these comments.

[The prepared statement of Dr. Kunz follows:]

PREPARED STATEMENT OF KEVIN KUNZ, M.D., M.P.H., FASAM, PAST PRESIDENT, HAWAII SOCIETY OF ADDICTION MEDICINE

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 the 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 (PRP) 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 that matriculated 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. While there is an anticipated development of new services in Hilo, this is presently more of a wish than a reality. Expanded services beyond the Hilo CBOC and Vet Center are needed, and since the PRP positions were relocated to Oahu, at least 5 new positions are needed now in Hilo: a Social Worker, a psychiatric registered nurse, a licensed practical nurse, a clerk, and a Certified Substance Abuse Counselor. A psychiatrist position already exists, but needs to be permanently filled.

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 preemptively 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 percent 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 percent 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 percent of all Operation Iraqi Freedom and Operation Enduring Freedom veterans are believed to meet criteria for PTSD.

Despite a welcome 8 percent 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.

Senator AKAKA. Thank you very much.

[Applause.]

Senator AKAKA. Sergeant Lum Ho.

STATEMENT OF SERGEANT GREG LUM HO, HAWAII ARMY NATIONAL GUARD

Sergeant LUM HO. Aloha, Senator Akaka and distinguished Members of the Committee on Veterans' Affairs. I am truly honored to come before you today to speak as a returning soldier who served in Operation Enduring Freedom in this Global War on Terror. I served with Bravo Company 193rd Aviation, of the Hawaii Army National Guard. Our unit has the distinction of being the first Hawaii Army National Guard unit to deploy to a war zone since the war in Vietnam, a distinction I am very proud of. Bravo Company 193rd was attached to the 10th Mountain Division while in Kandahar, Afghanistan, and we provided Army aviation intermediate maintenance support for all Army aircraft on Kandahar Airfield.

While I have nothing but positive things to say about my time in the sandbox, it is the support back home that I'd like to address to you today.

While our unit was mobilizing prior to our deployment, there were a lot of programs that would be provided to the families while we were on this deployment. But when I would inquire if these services would be provided to our families back on the Big Island, the same answer I got every time was, "Sorry, only on Oahu."

Now, I don't blame the Army. They were not prepared for the unique situation that arises here in the State of Hawaii. When they deploy troops stationed at Schofield Barracks, every soldier lives on Oahu and has access to these programs and services on Oahu. Being that we were National Guard members, they were not prepared to deal with these programs—to deal with the soldiers' programs and services, like storage facilities and child care, to more important things like medical care, here on the Big Island.

So our families were literally on an island having to take care of themselves. My wife Imelda, who headed the Hilo Family Support Group, would make frequent phone calls to check on the well-being of other families on the Big Island. She would later tell me that she did it more for herself. Knowing that other families were going through the same situation she was going through, while the families she was contacting thought she was supporting them, it was actually them supporting her.

After returning home, the way I found out about the Vet Center was through Lieutenant Colonel Harlan, who is also currently with the Army National Guard. He is also the team leader at the Department of Veterans Affairs Hilo Vet Center. He provided outreach services to our families and mentioned that he worked at the Vet Center and would like to discuss, on behalf of the Vet Center, provided outreach programs to veterans and their families.

I mentioned to him that I had a few soldiers that could use some assistance, and if he wouldn't mind speaking to my soldiers from Hilo. We were all in for a surprise, as I'm sure Lieutenant Colonel Harlan was, to find out that many of these programs were not mentioned to us in any out-briefing since returning home.

Needless to say, we learned a lot that day, and wish that more time could be set aside for people like Lieutenant Colonel Harlan and his staff to speak to returning Guardsmen. I have seen my men and women literally grow up to become soldiers proud to wear the uniform. I just want them to get a fair shake as veterans.

Of course, not all was negative with our families while we were deployed. Lieutenant Colonel Laura Wheeler, who was in charge of the Hawaii National Guard Family Support Program, kept my wife informed on any updated information. She called my wife Imelda numerous times, and even flew out to Hilo occasionally to meet with the Hilo families. She even set up question-and-answer sessions with Governor Linda Lingle and the Adjutant General, Major General Robert Lee. These meetings provided a comfort to the families we left behind in Hilo, knowing that just because we are from the neighbor island, our families were not forgotten.

In closing, I would like to say that I am proud to be an American soldier, and I wear my combat patch proudly. But for all the awards and decorations I have received, it is the loved ones we leave behind who hold the family together who are the true heroes. I commend them all.

I thank you, Mr. Chairman, Senator Akaka, and your Committee for allowing me to speak before you today. It was truly an honor I will never forget. Thank you.

[Applause.]

[The prepared statement of Sergeant Lum Ho follows:]

PREPARED STATEMENT OF SERGEANT GREG LUM HO, HAWAII ARMY NATIONAL GUARD

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When they deploy troops stationed at Schofield Barracks. Every soldier lives on Oahu and has access to the programs and services the Army provides. Being that we were National Guard Members they were not prepared to deal with soldiers programs and services like storage facilities and child care to more important things like Medical Care. If a family needed to see a medical professional they would have to travel to Tripler Army Medical Center on Oahu, I'm sure at their own expense. So the families were literally on an island having to take care of themselves. My wife Imelda, who headed the Hilo Family Support Group, would make frequent call to check on the well being of the other families. She would later tell me that she did it more for herself. Know that other families were going through the same situation she was going through. While the families she was contracting though she was supporting them, it was actually they supporting her.

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But for all the awards and decorations I have received it is the live ones we leave behind, who hold the family together, who are the true heroes, I commend them all!!

I thank you Mr. Chairman and your Committee for allowing me to speak before you today. It was truly an honor I will never forget.

Senator AKAKA. Thank you very much.

Katherine King.

STATEMENT OF KATHERINE KING, VETERAN

Ms. KING. I would like to first introduce myself. My name is Katherine King, and I am a 100 percent service-connected disabled veteran. I suffer from PTSD rated at 100 percent, bladder injury rated at 60 percent, loss of reproductive organs rated at 50 percent,

bowel resection rated at 10 percent, and hypothyroid rated at 10 percent. I bring these issues to light as to why proper medical attention is so vital here.

Before I start, I would like to take this opportunity to thank you, Senator Akaka, and all of your staff, with special thanks to Dahlia Melendrez and Robert Mann, for taking the effort to come to Hawaii and personally addressing veterans' health issues. I also want to thank you for the honor of allowing me to testify before you.

Before becoming a resident to Hilo 2 years ago, I had been living on Oahu for many years. The care on Oahu was considerably more professional than what I have experienced here in Hilo. I find this quite distressing, since it would seem that all veterans should receive equal quality care because we were all willing to give our very lives for this country when we were needed.

The workload and lack of resources on the understaffed at CBOC Hilo is so overwhelming by the constant needs of veterans that they have become desensitized. It is so bad, in fact, that they had to hire a security guard. Because of these circumstances, it is the veterans that bears the brunt of the extreme stressed-out environment that exists here.

If better quality care could be given via more doctors and nurses hired, waiting time reduced, and a more pleasant environment augmented, a security guard would not be necessary because they already have bullet-proof glass windows installed.

There are no doctors designated for walk-ins, nor any on-call psychiatrists. As a matter of fact, psychiatrists and other staff members leave CBOC in shorts periods of time, like a drive-through hamburger joint.

PTSD victims do not schedule when they're going to have an episode. It is not an 8 a.m. to 4 p.m. disorder. Because there are no 24-hour services available, and because of the recent removal of the PRRP program, veterans like myself with PTSD and other mental health issues tend to self-medicate because the pain inside becomes so great, it is either self-medicate or suicide.

I cannot bring myself to a civilian psych ward that does not have much knowledge or experience with military veterans. It is too frightening of a thought. I have endured, by the grace of God, many nights of hanging on by my nails. But just how long does a veteran have to endure before they cannot hang on any longer?

CBOC hired a female psychiatrist, and then fired her a few weeks later. She was helping me. Female veterans need female therapists. I am not comfortable with male psychiatrists, and please, do not get me wrong, I am not saying that they're not any good. I am just not comfortable discussing sexual assaults with men therapists at this time.

If you need care after hours, we have been told to call 1–800–214–1306 and get authorization for the ER. It is nearly impossible to reach a live person with this number. You are kept on hold until you just cannot take another hour of hold time. It is very difficult to hold a phone to your ear when you are very ill and in need of acute care. Can you just imagine a veteran having a heart attack or stroke stopping to call a useless 1–800 number prior to going to the ER? Well, that is exactly what this system expects.

Another 100 percent service-connected veteran told me that they called this number the other day and they actually got a live person, but was told that it was not an authorization number. The veteran was told that you just go to the ER, and maybe Fee Basis will pay for it and maybe they won't. I have several large doctor bills that I had to pay since moving to this island because Fee Basis has denied every claim that I have submitted.

This creates another issue. Because I live on a fixed income, I have been going without after hours urgent care because I cannot afford the bills. I am not one to abuse the ER—please check my records—neither have I gone without care since becoming 100 service-connected in 1995 until I moved here. I invite you to call this 1–800 number that CBOC or Fee Basis has demanded veterans to call for authorized ER care. Please, just see how it is for us.

If you go to CBOC as a walk-in, this is the time-consuming steps it takes for the sick, frail, and fragile veterans to complete in order to receive care.

You check in to CBOC, and you wait no less than 2 to 3 hours. You will not be called until all the appointment vets have been seen unless the staff gets it, that you are acutely ill and/or begging for help.

Once seen by a CBOC doctor, you are authorized to go to the ER across the street. Have you ever been so sick, sir, that you could hardly walk 10 feet, but yet you are expected to cross a busy highway and then walk up 25 flights of steps to sit in the ER another 2-plus hours being called in by a doctor, then another 2-plus hours before all your test results come back. While waiting for the tests, the ER could heavily medicate you.

Once discharged back to CBOC, you are then expected to walk, heavily medicated, back across the busy highway to sit in CBOC for up to an hour waiting for a piece of paper authorizing you to pick up your medications from a civilian drugstore.

Once you have that paper in hand, then you go to the drugstore and you sit there for up to 2-plus hours waiting for your medications.

This process is way too long and too much to ask for veterans that are sick, frail, and fragile. A suggestion that may help is to have the ER dispense the medications right there, or the ER fax over to CBOC the prescription, and then CBOC fax the authorization to the local drugstores.

The ER at Hilo Medical Center makes good money off of veterans. They could also provide transportation back to CBOC if the veteran is heavily medicated by the ER staff because you do not want to move your car once you find parking because parking can be difficult at times.

I challenge you to come here and go through a day in the life of any veteran of your choice. Come and see the ridiculous red tape and bad attitudes that the veterans face daily here with their care, or lack of.

Why is it that in many States, CBOCs do not exist? The VA regulations in those States are: If a veteran lives outside of a 40-mile radius of the nearest VA, then Fee Basis pays for the care. No hoops, loops, or bureaucratic red tape. The veterans in those States see the same doctors, and do not have to keep repeating their med-

ical and mental health history to a new staff member every other month.

As a veteran, I am not asking for anything impossible. I am asking for a little consideration, respect, and proper medical care. Instead, people on welfare receive better quality care than our veterans on this island.

Although there could be more issues to address, I will sum this up with one final point, and that being, my dear Senator, I want you to know personally and it be made part of permanent records that the fear of losing my benefits has been put to me by several people. People have advised me that if I rock the boat or make too many waves, the system will come gunning for me. It is my sincere prayer that this is false and you truly want to know the truth.

It has taken a lot out of me to set aside my fears and testify before you today. I sincerely appreciate your extensive workload, but I please ask you to see it from our eyes. Thank you.

[The prepared statement of Ms. King follows:]

PREPARED STATEMENT OF KATHERINE KING, VETERAN

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of acute care. Can you imagine a veteran having a heart attack or stroke stopping to call a useless 1800 number prior to going to the ER? Well, that is exactly what this system expects.

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I sincerely appreciate your extensive work load, but I plead with you to see it from our eyes.

Thank you.

Senator AKAKA. Thank you very much, Katherine. I know it has been difficult for you to come this far with it. But first, let me thank you for your service to our country. We really appreciate that. And I also appreciated your comments. This is exactly the

type of information we need to try to make things better. And so I thank you for that.

My question to you, Katherine, is, what does the closure of the PTSD unit in Hilo mean to you?

Ms. KING. I have no place to go to keep me safe from me at times. At night—the nights are the worst for me. Daytime I do fairly good. But the nighttimes are the worst, and I have nowhere to go.

When I would get attached to—they would bring in a female therapist. Beth was one of them. Then they brought in Dr. Klein. I started developing a relationship with them and they were actually helping me. But then I don't know what happened. They're not there.

Senator AKAKA. Thank you.

Sergeant Lum Ho, I too want you to know that I appreciate your service to our country. I also appreciate your comments here, and especially the insight that you provided us in your testimony.

Let me assure you that I will work with my staff to ensure that our Guardsmen and Reservists on the neighbor islands receive the services and attention they deserve. We will certainly be working on this, and I thank you for letting us know. Because you can tell from the testimonies today, the questions, that families are very, very important to us, too.

Sergeant LUM HO. Yes, sir.

Senator AKAKA. And if we cannot take care of the families, then it affects the troops.

Sergeant LUM HO. Right. If I could add something, sir?

Senator AKAKA. Yes.

Sergeant LUM HO. We were the first unit from Hawaii National Guard, like I stated. But I see vast improvement with the returning troops, with the out-briefings. When we came home, it was like, OK, here's your checklist. Get this done, and your deployment is over.

Now you see more—I was sitting in Colonel Harlan's office preparing my statement, and you see young veterans coming back from Iraq signing up with the Vet Center. And so I know the word is getting out. It's just I don't want my unit to be forgotten just because we were the first one there.

But I do see the generals are speaking about the outreach programs of the 25th. I was with 10th Mountain, and it seems like we got forgotten. But I do see improvements, and that's a testament to everybody that's—90 percent of the Hawaii National Guard has deployed. People like Lieutenant Colonel Harlan getting the word out, I really appreciate that. Thanks.

Senator AKAKA. Thank you, Sergeant.

Dr. Kunz, in your testimony, you recommend a new set of outreach efforts to be implemented for veterans and their families. What do you think is the most effective way to conduct outreach to veterans and their families?

Dr. Kunz. Senator, I don't think that having a table at a welcome home ceremony or a reunion is enough. The veteran that truly needs care is going to end up accessing it through family members or other community resources. The vet themselves, as one of the gentlemen said this morning, is going to take line A that's "Go

home" and not line B that's "Sign up for services." It may be 20 years before they're ready to sign up for services.

So we must reach the family and we must reach the community. And so it needs to be at community events. It needs to be public service announcements. There needs to be a new visibility to the Veterans Affairs and DoD workers across the country that integrates those conditions that veterans have coming home with the general thought of what is health in America. We are ignoring and denying the existence of this disease if we just go to where we expect the veterans to come and have some ice cream and cake.

So I would say, and I don't have any specific ideas, but we have to break out of the mold that really isn't working or we'll find ourselves in 5, 10, 15 years with the onslaught we now have of Vietnam veterans that are still coming forward.

So to beat that, the table with the brochure and the vet is great, but it's not reaching the guys who need it the most. We need community education and family education.

Senator AKAKA. Yes. I thank you for mentioning that, too, in your testimony about the community and its importance. And I thank you again for this about reaching the family. I did mention this at one time—last year—where I went to a meeting and I noticed a person who was sort of hanging around.

Finally, when I went to the parking lot, there he was. So he wanted to see me, only to tell me about his son. He said, "My son was one who liked to surf. He would go out with his friends. He always had a good time. He was never home."

He went to Iraq at the beginning of the war and now he is home. And so he went to his son and said, "The surf is up. Why don't you go surfing?" He didn't want to. "Why don't you go to—call your friends up?" He stays at home and just sits at home.

And he said, "I'm worried about him." You know, now, this is coming from a father to me. We really need to get to the fathers and mothers and wives and husbands to try to get their help to let us know really what is wrong.

Also, I mentioned about culture in Hawaii. We're very diversified. And, you know, we have types of folks here who don't want to admit they need help. They'll never admit it. But the families see it and the families can tell us. And as I mentioned earlier, you know, after you talk to them and ask them, what's wrong? Oh, I'm OK, and just let it go at that, and on.

But we need to try to reach them. And that's why I asked that question because you had ideas. Thank you for mentioning the family, instead of the table with all the information. Maybe this is part of the problem facing Sergeant Lum Ho. We need to go beyond the troops and go to their families to see what kind of help they need. Well, thank you for that.

Mr. Harlan, how can we—and when I say "we," I mean VA—better utilize Vet Centers and its services to reach out to the veterans in Hawaii?

Mr. HARLAN. Well, Senator, I think the first step has already been taken with the funding that you've provided for the outreach workers. I would like to see that expanded so that maybe more of them, like Dr. Kunz is saying—I mean, our goal for our outreach

worker is that they're going to be going to actually visiting people in their homes, not just at, you know, some table event.

But their job is full-time outreach, where they'll be out at every kind of event and making—contacting—like one of our goals is to contact every single soldier and their family who came back, every single one, and to make sure that every one has been contacted by us; and then to follow up in a couple months and years, and to—when I mean contact, it's not only with the soldier, but with the family.

And so the family can feel free to call us and tell us if they think that—like the father said to you. Because we're already having that also. I've had an exact story like that just in the past couple of weeks, where the soldier has returned to Hilo but he won't return home. He has yet to visit his family because of what's going on in his head. Luckily, he's visiting us, but not frequently enough.

So, you know, the outreach. And Vet Center staffs, in my opinion, we need—you know, the workload and to provide quality care is we need more staffing, you know, so that we frequently can meet with people, not the limited number of sessions that we can offer.

And for another concern I have is, as Ms. King mentions, there's many female veterans returning. We need more female therapists to be around. We did have, and now we don't. And I have had a number of female soldiers who have returned who stated they had suffered various events in Iraq and they felt, you know, rather uncomfortable discussing it with me as a male. But I'm their only choice right now.

And so, you know, I try to be as empathetic as possible. But, you know, with no females available or even under contract, you know, it's a great concern because approximately 40 percent of the soldiers are female now. And the numbers of them who suffered sexual harassment at the very least, I was kind of shocked by some of the things I've heard by the returning females.

Senator AKAKA. Thank you so much for your remarks.

I want to tell you that our whole effort here as a Member of Congress, the U.S. Senate, as Members of our Veterans' Affairs, as members of our armed services, as folks and citizens of Hawaii, that we are getting the message from you. We're trying to provide the best we can, but we know we must do better. This is what we're trying to do.

Now, what we've heard from you will help us do that. And this is why we're happy to have you, you know, say what you really feel about your situation. And Congress, for instance, you mentioned funding. Funding is limited. Funding has been difficult. The Veterans' Affairs Committee is not viewed as a top Committee. As a result there is limited funding.

Chairman Craig and I have been working on a bipartisan basis and working well to turn things around. And we're looking for ways of increasing that funding. And what we're saying now is we cannot take what we get in funding. We want to ask for what we need.

You're telling us what you need. So that means that we're going to have to increase that funding. So we're looking for ways of doing that.

Secretary Nicholson, Dr. Perlin and his associates are the ones who will be working on this. And what they've heard will help them.

Of course, there are limits. But I want to tell you Dr. Perlin did mention in one of the hearings that in the future, the services will be different because of technology. Senator Craig also mentioned this, that the delivery of services will not necessarily be institutional. It's going to have to change, using technology, so that services will be different. It has to be different.

So on their level, they're trying to do better as well. Of course, from our side, we have the inside duty and responsibility. So we keep an eye on VA and try to help them out to do the best job they can, too.

And of course, our military and delivery of security is very, very important to them, and the attitudes, the feelings, of the troops and their families are very important to them. Otherwise, you know, they're not as capable as they can be. So you see all of these levels are affected. And we're all trying to improve this.

Now, on the military level, too, I think all of you know that we've been building quarters for troops. Now, this is part of raising the quality of life for our troops and their families. So all of this together is the effort of trying to improve whatever we've been doing.

But I want all of you to know that this is not finished. In Hawaii, we use the word "pau." It's not pau. It's still going on. And we are looking for ideas and better ways of doing something better. And with the use of technology, we expect to see this kind of changes coming about. This is why I'm so happy we've had these hearings. This is the last hearing of a series here in Hawaii. It will really help our Committee do our job in Congress.

I'd like to take the time to express a warm mahalo nui loa to Blaine Hanagami [ph] and Charlie Kunz [ph] for helping us set up this hearing. It was set up nicely, and we've conducted a good hearing.

I'd like to recognize Barbara Fujimoto [ph] and Beverly Chang [ph] from the Hilo CBOC. I'd like to thank Sergeant Alan Kellogg [ph] from VBA and all of the VBA staff who have come to all of our hearings. Thank you so much.

I'd also like to recognize Janice Nielson [ph] on the front row, who has been with us through our hearings, and for all that she does just by her presence. And Major Rick Starz [ph] and all DoD personnel who have joined us as well. I really appreciate all of that.

I'd like to again recognize my staff who have been working for many months to coordinate these hearings: Blaine Saito, who has transcribed every hearing. Michelle Moreno, Alex Sardegna, Dahlia Melendrez, Rob Mann, Pat Driscoll, Ted Pusey [ph], Donalyn Dela Cruz, and John Yoshimura. This is my staff.

Again, I want to mention the chief of staff of Senator Craig, Lupe Wissel [ph], who's here, and her staff, too, who's here and helping out. I'd like to especially thank Kim Lipsky [ph] from my staff for all of her hard work in setting up these hearings.

Finally, I'd like to thank all of you, Hawaii's veterans, for your dedication and sacrifice in making our State and Nation so great.

Really, we do have a great Nation, and I can tell you that because I travel in Congress, and we go to other countries as well.

When you look back at our country when you're there or when we're at home, you can feel the difference. And we're so fortunate. We have a lot to be grateful and thankful for, and I thank the Lord and thank God.

But, you know, we have lots of work to do.

I will take back your mana'o or your thoughts as I've heard them these days, including all of your written testimony and comments that we received, and work to see how we can improve the care and services which are already, I should say, stellar, and what I mean by stellar is you know that—and it's a fact—that our Veterans Administration is rated as the highest kind of service of healthcare that we have in our country. Thanks to them.

And also, for our Hawaii veterans, because they have served our country so well and we're proud of all of them.

So together and united, we will continue to work to make things better for all of us. Mahalo nui loa. A hui ho, which means we'll meet again, and I want to wish you well in 2006 and the years ahead. And let us be grateful and thankful for all that we have.

Thank God. God bless America. God bless all of you. Aloha.

[Applause.]

Senator AKAKA. The hearing stands adjourned.

[Whereupon, at 12:40 p.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF FLOYD D. EAGLIN

I am a Disabled American Veteran rated at 100 percent and housebound because of PTSD and physical injuries I received while serving in Viet Nam. I am also a life time member of DAV organization and belong to Chapter 6 located on the Big Island. There are several issues that I would like to bring to your attention regarding the Department of Veterans Affairs medical services to veterans in the county of Hawaii:

1. The county of Hawaii has approximately 15,000 veterans residing on the Big Island.

2. There are approximately 8,000 veterans living in east Hawaii. Presently there is only one (1) social worker to provide both medical and social advice to all 8,000 veterans which makes her task impossible.

3. Because of the limited number of Social Work positions on the Big Island, Veterans have to wait a long time to get help. A simple call to the Social Worker, takes a week or more for a reply. There are no outreach programs that provide social services to all Big Island Veterans. Some of these veterans are unaware of the services the Department of Veterans Affairs has to offer, such as medical, housing, financial, social, and etc.

4. Many veterans and my-self included, believe that the Department of Veterans Affairs' Officials are not listening to our advice or recommendations as to how "the Veterans" could be better served. Example: Veterans wrote numerous letters recommending that the PRRP remain in Hilo. The serene and low-keyed environment that Hilo provided, along with the integration of the community activities that were program requirements helped with the overall therapeutic well being of veterans in the program. We were informed by VA Officials, that no one wanted to work in Hilo. When we pointed out that this was not the case, we were ignored. (As a matter of fact two of the employees, who are veterans, went back to school and attained their Master of Social Workers degree and State of Hawaii licenses. To my knowledge these veteran employees were not promoted to the entry level GS–9 positions and therefore never given their year of supervised training in order to meet the qualification required by the VA to fill the GS–11 vacant positions).

On several occasions I requested and challenged the Department of Veterans Affairs managers in Honolulu and Hilo to put into place the Minority Veteran Outreach Program as set forth in the VA Hand Book 0801 that is supported by "38 U.S.C., Part 1, Chapter 3, Section 317, Center for Minority Veterans."

I informed these managers that this would insure that the needs of all Minority Veterans would be addressed in every aspect of the Veterans Affairs' nationwide delivery of services and benefits. The mission of the Minority Veterans Outreach Program as defined in VA Hand Book 0801 states that adequate representation for all veterans in every phase of treatment will be provided.

In other words, more emphasis should be placed on "representation of the veteran population served" in the Therapeutic Setting. This would insure that all veterans would be afforded equal access to all VA healthcare and benefits.

In closing, I would like to thank you for this wonderful opportunity to be a part of the Senate Committee on Veterans' Affairs hearing, entitled "THE STATE OF VA CARE IN HAWAII."

PREPARED STATEMENT OF BUD POMAIKA'I COOK, PH.D.

Aloha Senator Akaka and Members of the Committee on Veterans Affairs:

This testimony is presented to inform the Committee on vital work being done in Hawaii to address the cultural needs of military veterans; especially those veterans of Hawaiian ancestry. Starting in 1990 with the Department of Veterans Affairs Vietnam Veterans Project and their report, "The Legacy of Psychological Trauma of

the Vietnam War for Native Hawaiian and Americans of Japanese Ancestry Military Personnel" and then again in 1998 when the Readjustment Counseling Service—Vet Center Asian Pacific Islander Veterans Working Group released "Asian Pacific Islander Veterans"—it has been consistently recognized that culture plays a critical part in the appearance of Post-Traumatic Stress Disorder symptoms. In 2005 Ka Maluhia Learning Center was contracted by Papa Ola Lokahi to work with a consortium of representatives from the John A. Burns School of Medicine, Native Hawaiian civic organizations, and Hawaiian veterans from the community to form a working group to launch the Hawaii Veterans Pu'uhonua Project.

The Hawaii Veteran's Pu'uhonua Project's primary purpose is to set up culturally-centered methods to assist Hawaiian military veterans lay to rest the affects of trauma experienced during their time of service. A secondary objective for the project is to use cultural education to resolve the impacts of cultural trauma also experienced by Hawaiian veterans. Healing this combination of war and cultural trauma will lead to improvements in veteran's health and well-being. The project is in the first year of an initial 7-year cycle of work. During this time emphasis will be given to community led research and intervention activities to determine the efficacy of cultural interventions for improving Hawaiian health. As the project advances its understanding of cultural trauma and cultural healing, it will share this knowledge with other Hawaiian and community cultural groups.

Attached to these introductory comments are two documents. The first, "Healing the Warrior Self—Changes in Kanaka Maoli Men's Health" is an article that appeared in the 2005 edition of The International Journal of Men's Health. The second, "Kanaka Maoli Men: Changes in Station, Changes in Health" is a draft of a chapter from a forthcoming book on Hawaiian culture and health. These are presented to inform the Committee as to recent research findings that affirm the causal link between the mental and physical health of Hawaiians with the social and historical trauma they are heirs to by birth.

The Hawaii Veteran's Pu'uhonua Project is in the first year of a 7-year program design to aid Hawaiian veterans and their families. The first phase of this project will gather the most current information from health care professionals working in similar populations in other parts of the United States, Canada, and the Pacific to determine the best ways for providing cultural services to remediate the impacts of war trauma. It is hoped that the Committee on Veterans Affairs will support this project and similar projects in Native populations.

Thank you for hearing this testimony on behalf of our Hawaiian veterans.

Healing the Warrior Self—Changes in Kanaka Maoli Men's Roles and Health

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HEALING THE WARRIOR SELF—CHANGES IN KANAKA MAOLI

Abstract

In the 225 years of contact with the Western colonial powers, the health and well-being of Kanaka Maoli (Hawaiian) men has declined dramatically. Studies seeking the causes for these adverse changes in morbidity and mortality do not demonstrate specific physiological or environmental sources for these declines in vitality. This paper describes pre-contact cultural structures that shaped and guided the lives of these men toward constructive and healthy ends. The authors pose an argument for socio-cultural factors that may be noteworthy in understanding lifestyle choices taken by pre-contact Maoli males. Some of these practices are considered for possible revival as they may produce positive changes in current negative health realities for modern Kanaka Maoli men.

Keywords: cultural trauma, men's health, Hawaiian health.

MEN'S ROLES AND HEALTH

The survival of a culture depends as much, if not more, on the continued existence, recognition, and celebration of a coherent self-perception—on the preservation of a cultural identity—as it does on the continued existence of a sustained population or physical boundaries . . . a culture can be destroyed or supplanted by other means than genocide or territorial conquest. A culture's identity is defined by its deepest values: the values its citizens believe are worth defending, worth dying for . . . And it is that "way of life" that warriors fight to maintain.

INTRODUCTION

Early European explorers arriving in what today is called Hawai'i, remarked on the amazing health and vigor of the indigenous Kanaka Maoli population, (Beckwith, 1932, p.74). In the 250 years since contact with Western colonial powers the resident culture of the Hawaiian archipelago has undergone a series of traumatic changes; some initiated by the indigenous population, but most forced upon them by contact with the modern world. The loss of an indigenous sense of self, one with a clear sense of traditional roles and responsibilities for native men has removed Kanaka Maoli males from connection to values and practices that once sustained their vitality and well-being at the highest level.

One marker of these changes is that presently modern Hawaiian men are consistently categorized in the most grievous of health status indicators. Studies in environmental factors and genetics have not fully answered questions as to why these declines have occurred, and why increases in morbidity and mortality are so virulent in this specific population demographic.

In this paper an explanatory model for understanding how social history impacts group health and well-being—Cultural Trauma Syndrome—is presented. Special attention is given to pre-contact Kanaka Maoli men's roles as the physical and spiritual protectors of their society. Through examination of changes in these roles, with special attention to indigenous warrior values and practices, the reader is introduced to a plausible cause for the decline in health and well-being of Kanaka Maoli men in the colonial period (1778 to present). Also, the way back to health through a process of healing education and cultural renewal is examined.

While focused on the warrior archetype and role, this paper is not a call for a revival of the ways of war-making by modern Hawaiian men, for they already swim in an ocean of anger and grief. This paper is instead a call for restoring the fullness of the values underpinning pre-contact Kanaka Maoli warrior traditions. These traditions encompass education, moral development, physical health, and social responsibility; all within the borders of a structure of life giving values. Amplification of these practices and values will allow present-day Hawaiian men to re-establish a state of personal and collective wholeness; allow them to once more be Maoli, spiritually true. As was done in the past, following these traditions is likely the most efficacious path for modern Hawaiian men to realize their journey out of dire circumstances to a fullness of health and vitality.

I. MODERN HAWAIIAN MALE HEALTH

These Indians, in general, are above the middle size, strong, and well made, and of dark copper color, and are, on the whole, a fine handsome set of people. (Beaglehole, 1967, p. 1178.)

Prior to contact with Western civilization, there was an indigenous population somewhere between 250,000 and 1,000,000 individuals (Jurvik and Jurvik, 1989, p.164) in the lands now known as the Hawaiian Islands. Current population statistics describe a completely different picture of the native population. In the year 2000 census, Hawaiians made up only 19 percent of the population or 239,655 individuals, of which less than 5,000 self-identified as full-blood quantum Hawaiian. From the start of contact with colonial powers in 1778, Native Hawaiian's have faced significant challenges to their health. They have the highest rate of infant mortality in the state at 8.9/1,000 live births, compared to 7.6/1,000 live births statewide (Office of Hawaiian Affairs, 2002). Although Hawaiians make up only 19 percent of the population, 45.7 percent of the live births are to an unmarried mother of Hawaiian descent. Hawaiians are almost twice as likely to have asthma as all other races in the state, (Office of Hawaiian Affairs, 2002). On average, Hawaiians children are physically hurt by an adult at twice the level of all other populations, and male children are abused more frequently than females (13.9 percent compared to between 3.2 and 9.3 percent of other ethnic groups in Hawaii), (Hawaii State Department of Health, 2002).

The disproportionate burden of illness only increases after childhood. Diabetes rates in Hawaiians are 2.5 times those of the general population of Hawaii, (CDC, 2004). Hawaiians also have higher rates of hypertension and death or disability from stroke than all other ethnic groups in Hawaii, (Hawaii Primary Care Association, 2002). In a study that indicates a possible genetic factor in these statistics, full-blooded Hawaiians have a heart disease mortality rate of 375.9/100,000 population, part-Hawaiians have a mortality rate of 146.8/100,000 population, and non-Hawaiians living in Hawaii have a rate of 68.2/100,000, (National Heart, Lung, and Blood Institute, 2004). In other words, full-blooded Hawaiians have a mortality rate from stroke 382 percent higher than non-Hawaiians, (National Heart, Lung, and Blood Institute, 2004). A question for future research is how the blood quantum

issue is tied to lifestyle choices affected by factors of historical and social disenfranchisement.

In addition, Hawaiians have the highest rates of age-adjusted cancer mortality in Hawaii when compared to other ethnic groups, and the second highest mortality rate from all cancers combined for all racial/ethnic groups in the United States (Hawaiians 207.2/100,000 are second and African Americans are first at 209.8/100,000), (Intercultural Cancer Council, 2001). Despite advances in diagnosis and treatment of cancer, mortality rates for Hawaiians have increased not decreased (by 62 percent for men and 123 percent for women between 1967 and 1990), (Intercultural Cancer Council, 2001). Cancer outcomes are also worse for Hawaiians, as their 5-year relative survival rate is 18 percent lower than Caucasians and 15 percent lower than the U.S. population for all cancers combined, (Intercultural Cancer Council, 2001). It has been hypothesized that this is due to late detection, lack of seeking care, lower rates of being medically insured, and lack of trust in Western medicine.

Hawaiians also have the highest rates of many risky behaviors, demonstrating a probable lack of value placed upon health and life. Statewide surveys demonstrate that 75.6 percent of Hawaiians are overweight or obese based on Body Mass Index, a number 50 percent higher than the other population groups in the state, (Hawaii State Department of Health, 2002). Hawaiians smoke cigarettes at an average rate of almost 60 percent higher than all other population groups (33.8 percent compared to 15–21 percent), (Hawaii State Department of Health, 2002). Hawaiian children from 12–18 years of age far outstrip their peers of all other races in use of tobacco, marijuana, cocaine, inhalants, methamphetamines, ecstasy, and steroids, (Office of Hawaiian Affairs, 2002). In the last 30 days 6.4 percent of Hawaiians drove after drinking, compared to between 1.3 and 2.6 percent of other ethnic groups, (Hawaii State Department of Health, 2002). Hawaiians have the lowest seatbelt usage, with 6.8 percent seldom or never utilizing seat belts compared to between 0.9 percent and 2.8 percent for other groups in the state, (Hawaii State Department of Health, 2002). Hawaiians, who make up 19 percent of the population of Hawaii, make up 39 percent of the male prison population, 44 percent of the female prison population, (Hawaii State Department of Health, 2002). Hawaiians comprise 29 percent of the homeless population, (Hawaii State Department of Health, 2002).

When examining overall health status, Hawaiians have the highest rate in reporting that their general health status is fair or poor (15.7 percent compared to 8.8 percent for Caucasians, 10.5 percent for Filipinos, 13.9 percent for Japanese, and 11.5 percent for all others) , (Hawaii State Department of Health, 2002). Hawaiians report the highest number of unhealthy days per month, citing a rate of 5.3 days in the prior thirty days at the time of the survey, (Hawaii State Department of Health, 2002), (Pobutsky, 2003, pp. 65–82). They also have the highest rates of disability for working age individuals, and they experience the most severe levels of disability in the state, (Pobutsky, 2003, pp. 65–82).

Feelings of helplessness, hopelessness, and powerlessness prevent people from taking proactive steps to improve their lives. The data listed above demonstrated that these feelings dispose them to choose the option of the more negative lifestyle choices more frequently than other populations. While there is little research demonstrating a causal relationship between a person's reported level of self-worth and impact on health, there is adequate evidence to support a subjective impression that frailty in one's self-esteem is tied to deteriorations in vitality, leading to early mortality, (Aboriginal Corrections Policy Unit, 2002, pp. 7–8, 23–24). It is the authors' hypothesis that political and cultural repressions faced by indigenous and other disenfranchised populations are probable contributing factors disposing portions of communities to increased levels of disease and earlier onset of mortality. With the loss of indigenous cultural mechanisms to support the formation of a positive self-image through expression of traditional men's roles, modern Hawaiian men are lacking critical guidance in their pursuit of personal vitality. Self-image, self-esteem, these and similar terms have emerged in the psycho-social lexicon to describe a person's self-perception, descriptors of structures by which one judges their worth in the world.

II. HISTORICAL AND CULTURAL TRAUMA

In order to understand how indigenous populations may have sunk to the bottom of most health status indicators, it is necessary to demonstrate a causal link between cultural health and physical health. For indigenous peoples who have been displaced, either physically or politically, in or from their traditional homelands, specific forms of psycho-physical trauma can now be described. Studies by the Canadian Aboriginal Corrections Policy Unit in cooperation with First Nations communities and private agencies indicate that aggression against a person's ethnic iden-

tity and community culture forms the basis for a recognizable trauma condition, producing discernable impacts on health and social development, (Aboriginal Corrections Policy Unit, 2002, pp. 7–8, 23–24). Brave Heart (1999), coined the term Historical Trauma Response to describe the way violation of selfhood a classified group feels in relation to their being identified, by self or others as a part of a historically disenfranchised population. These violations are perpetrated when the individual and their group are described as different in race, culture, and/or creed, from the peoples of the incoming colonial power.

Cultural Trauma Syndrome (CTS) is a structure for describing the dynamic link between cultural identity and personal well-being. The entwined formations of CTS bring to light distinguishing social traits that may authenticate a causal relationship between ethnic identity and long-term health. Significantly, CTS is designed to account for individuals who may not have lineal origins in a targeted culture, but are people whose sense of personal identity is rooted in specified, disenfranchised culture. CTS specifically addresses the trauma of individuals whose familial lineage is genetically linked to the communal history of a subjugated culture. Cultural Trauma Syndrome can be seen in a series of defining formations:

1. This injury is a process of cultural genocide.

Targets cosmology, epistemology, pedagogy, and social structures as objects for repression It is not necessarily linked to declines in population. However, rapid declines in cultural population numbers usually correspond with actions of cultural assault.

2. Attacks on indigenous social norms bring breakdowns in many normative cultural social structures. Breakdowns occur in traditional religious and spiritual boundaries, forms of community leadership, family configurations, and gender specific social roles Lack of continuity and understanding of traditional social structures slows cultural renewal.

3. Trauma related events and perceptions of their intensity do not, by necessity, have temporal continuity. What may not have been felt as injurious by one generation of a population may be experienced as an offense by later generations.

Cycles of severity may correspond to modifications in political efficacy.

4. Sources for injury may come from within, as well as from outside a defined cultural group. Disenfranchised individuals and sub-groups take on the role of perpetrator of cultural wounds as an adjunct to violations originating from outside the cultural group.

Internal divisiveness reduces advocacy for healthy relationships with other cultural groups

5. Incidents of traumatization have inter-generational transference. The mechanisms of Cultural Wounding keep the insult of a trauma event activated across time.

Insults may remain dormant for long periods of time, only to be rejuvenated by recent events. Cultural Wounding is a term distinguishing specific incidents of violation to a person's sense of culturally centered self. These insults are tied to some form of cultural, ethnic, or racial artifact. These artifacts might include one or more of the following:

a. physical characteristics;
b. family genealogy;
c. indigenous intellectual or aesthetic property;
d. geographical place of origin;
e. traditional religious practices;
f. forms of indigenous government or commerce;
g. traditional social practices, gender roles, family pattern, etc.; and
h. distortions of the historical record.

Cultural Wounding is a confrontation, an incident of psychological, spiritual, and/or cultural injury. It is the mechanism by which the historical cycle of trauma is revisited upon an individual or community. It is the means by which the wound of a previous generation is made fresh in the minds and spirits of those living in the present. Cultural Wounding is the mechanism that accounts for the power of social and cultural trauma to last for several generations of time. Cultural Wounding is the way contemporary persons are linked into the continuum of Cultural Trauma Syndrome suffered by their people.

III. THE WAY IS LOST—THE COLONIAL PERIOD

The Veil of Isolation is Pierced

Now it is possible to more fully understand the dynamics of change that caused the once healthy and vital Kanaka Maoli male population to descend to the unfortunate state they are found in modern society. In the late 18th Century, the indige-

nous Hawaiian society was in an advanced stage of development, rapidly changing from a multi-island tribal society to a proto-state. The people of this land, the Kanaka Maoli, lived their lives in accord with a philosophy founded in an intrinsic balance of opposites—in all things, for all cultural functions. Men and women had corresponding, and sometimes contrasting responsibilities in many areas of community development and function. Kanaka Maoli men were responsible for not only their gender-based tasks, but also for preserving the integrity of Loina Kane, the Male Aspect of the Kanaka Maoli Sacred Law, the 'lhi Kapu. In the last 250 years Kanaka Maoli men have lost essentially all of their traditional social and religious responsibilities; thereby losing a functional source point for much of their native sense of self. This loss of selfhood is a point for examination in determining its impacts and ties to significant health disparities present in modern Hawaiian men.

When the ships of European explorers arrived in the Hawaiian archipelago in the late 18th Century, an all too familiar set of social and cultural transformations, changes common for many colonized indigenous peoples, were set into motion. Arrival of these strangers was, from the perspective of cultural sustainability, unfortunately coincidental with local events that had been unfolding for almost 100 years. A long-standing internal war between several powerful tribal groups in the archipelago was coming to a decisive moment in time. The balance of local political power had been contested in a series of regional conflicts with the center of preeminent power shifting from one island to another, cycling back and forth across the island chain. Warfare had progressed from isolated, low intensity inter-tribal conflicts to inter-island rivalries of armies numbering thousands of combatants.

New Ways of War Making

Contrary to popular images of surprised natives, even at Cook's arrival in the islands in 1778, local chiefs were not intimidated by displays of Western war technology. In truth, these leaders were quick to grasp the potential benefits to their cause, quickly seeking to harness these weapons for their own needs. Alliances with Western ship captains were quickly sought, with several chiefs adapting their war making potential by integrating the new weapons. New weapons necessitated new tactics. Western advisors and allies were sought to adapt Kanaka Maoli military tactics to deploy the new weapons systems to maximum effect. These alliances were not relationships built on a shared sense of political idealism; they were largely predatory in nature. Each side sought to gain ascendancy for their personal political and commercial interests.

The new weapons brought with them the advantage of distance in making war. Except for the Ka ma'a, the sling, the Kanaka Maoli traditional technique for making war upon others was an intimate affair; hand to hand combat supported by slashing, piercing and impact weapons, plus sophisticated systems of grappling arts. Because of their increased killing range, the new weapon's technology allowed for depersonalizing the violence of war. These new methods also increased the numbers of dead and wounded in battle. And, most importantly, this increase, depersonalized violence was accomplished without the traditional and spiritual warrior's bond existing between perpetrator and victim.

The new weapons and tactics allowed a common foot soldier to take the life of the most sacred chief; highborn men that were the most highly trained and skilled in the warrior arts. This killing could occur anonymously and outside the credence of honor-centered values seen in the previous period of more intimate forms of combat. In the traditional Kanaka Maoli approach to war, significant import was given to the spiritual ties binding combatants to one another through the relationship of combat. Combatants became bonded to one another through the hazards of falling at each other's hand. The Kanaka Maoli believed that a life taken in battle belonged to the victor forever; that the soul of the vanquished would remain the relic of the victor's until his own death. With the new weapons no one might ever know who had killed any one person lying dead upon the field. No one was then held responsible for the release of the fallen warrior's spirit into the nether world of PO, the Kanaka Maoli source of origin. No one could then properly usher the released spirit through its proper transition from this plane of existence on to the next.

In a battle where weapons allow violence to be conducted at great distances, it is almost impossible to know in any specific way, who perpetrated violence on whom. In traditional Maoli warfare it was vital to know who had killed whom. For the Kanaka Maoli there was a tie between combatants, a relationship that demanded proper social observation, for example: after the battle, who could claim the chief's Mana, his spiritual strength? And then, who should assist his spirit to transition from this plane of existence to the next? And most importantly, when confronting the issue of war trauma, with the new distance-oriented weapons, how

would any individual account for his specific actions in the post-battle rituals for washing away of spiritual profanity taken on by the commission of violence?

The release of violence and the spiritual malaise that accompanied war was a psycho-spiritual matter the Kanaka Maoli addressed in pre- and post battle rituals. The violent release of a person's spiritual power in battle brought significant psychic burdens to bear. The psychic stain upon the soul of the survivor was expiated through post-battle rituals lasting for several days, culminating with the ritual rebirth of the warriors in a temple site specific to the female principle. Through rituals common to many Maoli tribal groups throughout the Pacific, warriors were cleansed of the stain of war violence, reborn into the world through ritual protocol, through ceremonies initiated at the women's shrine, the Hale '0 Papa. (Fornander, 1974, pp. 26–29) provides one illustration for the Kanana Maoli vision of life/death/rebirth in a translation of a prayer that was recited at the Hale '0 Papa:

E ua maika'i ae ne'i keia po o ko Akua Wahine.
A'ole e ola na wahine waha hewa mai is 'oe
E make 'ia i ko Akua Wahine.

This night has been favorable because of your female Ancestors, Life is not granted to those before you by the Female Ancestors with satiated mouths.

They (the warriors) will die at the hands of the Female Ancestors.

After the abrogation of the native religious system in 1819, a change perpetrated by a narrow segment of the conquering elite, ritual renewal was no longer available to provide relief from the psycho-spiritual stains acquired in life. The removal of this potent structure for reconciliation of violence, one that renewed health and order in Kanaka Maoli, post-battle society was not replaced by a correspondingly powerful Western system. Without these rituals and their supporting moral structures, post-modern Kanaka Maoli men lost an important social and spiritual support for self-identity and a vital way of release from the afflictions of violence.

ADDITIONAL CHANGES IN SOCIAL STRUCTURES

Authority and Governance

With the completion of Kamehameha Pai'ea's campaign of conquest and consolidation of the islands into a single administrative entity in 1805, the region entered a new period of social control. Until this time the islands were largely ruled by individuals born to chiefly families from regional tribes, 'Oiwi. Pre-1780, a single island might have dozens of people fulfilling a variety of community leadership roles. Under the political regime of Kamehameha Pai'ea, a smaller group of people, largely from Hawaii and Maui islands ascended to rule the archipelago. With the death of Kamehameha Pai'ea, his son and heir Liholiho (also known as Kamehameha II), instituted the beginning of a monarchical government in the style of the European courts. Under his rule the government of the island chain evolved from chiefdom to modern kingdom. The form and shape of governance continued to evolve in form and structure throughout the 18th century. The native government eventually became a modern constitutional monarchy with treaty relations with all of the major colonial powers. This government continued until 1893 when it was conquered by immigrant and military forces of the United States, eventually becoming a Western-styled democracy under the flag of the United States.

LOSS OF WARRIOR/SPIRITUAL RESPONSIBILITIES

Kanaka Maoli tradition held that men of the Ali'i, ruling, class would have concurrent religious and military responsibilities. Following conquest of the island chain by Kamehameha Pai'ea, primarily to prevent their being used to overthrow the conquering government, all established military groups, except for a small force loyal to the King, were disarmed and disbanded. Therefore, from 1805 onward, Kanaka Maoli warriors as a distinct social class ceased to exist in any functional manner; either as war fighters or as protectors of the spiritual life of the community. Traditionally Kanaka Maoli males were the warrior/protectors of their physical society, but, more importantly, they were also the protectors of the spiritual well being of the society. Kanaka Maoli warriors maintained the subliminal will that sustained the mystical glamour of ritual, protected rites that would forever shield Maoli-kind.

In 1819 the state religion of the Kanaka Maoli was dismantled by the ruling elite, bringing further decline in men's social and spiritual responsibilities. On the death of Kamehameha Pai'ea, his primary wife Ka'ahumanu, declared herself Kuhinanui, regent, to the heir. She then ordered the new chief Liholiho to join her and his mother, the sacred chiefness Kapi'olani, in disbanding the existent Maoli religious system. Her motivation for this radical decision appears to be solely concerned with

the preservation of war booty, primarily in the form of land holdings for her family. With this pronouncement, all of the spiritual foundations that balanced the violence of the warrior with efforts of moral rectitude and all of the ceremonies providing for reconciliation and redemption from violence were removed from society-at-large. This edict effectively ended the uniquely Kanaka Maoli tradition linking spiritual and warrior practice. Coincidentally, less than one year after the abrogation of the indigenous religion, Calvinist Christian missionaries landed in the islands to begin a campaign of spiritual conquest on behalf of their religious ideals.

Removing men's function as the warrior/protectors of the society, while also removing their ritual and cosmological basis for developing meaning, is a case in point example of a powerful process of cultural wounding. This twofold loss for indigenous men has been seen in other populations.

Warriors are supposed to repel the enemy and insure the safety of the community; when this is not possible, defeat has deep psychological ramifications. Add to this the destruction of men's roles in the traditional economy, and you have men divested of meaningful cultural roles. (Duran and Duran, 1995, p. 35).

DEPOPULATION AND THE NEW RELIGIONS

Beginning with the arrival of the first European ship in 1778, with its cargo of new diseases and continuing through to the end of the 19th century, the native population in the islands was reduced to 10–20 percent of its pre-contact size, (Stannard, 1989, p.51). This traumatic decrease in aboriginal census led to striking changes in communal patterns and lead to an increase in Western values arriving with immigrants into the kingdom. In large part due to this massive loss in population, norms for social relations and family structures were set aside. For example, in pre-contact times when seeking a mate, a Kanaka Maoli individual would have been quite conscious of class distinctions based on genealogical implications. With the loss of so many, and the loss of the defining philosophical structure of the state religion, families intermarried in patterns not usually existing before the loss of so much life.

Ancillary to the devastation from disease was a corresponding loss of confidence in royal control over the physical world, (Kame'eleihiwa, 1992, p. 82). Even though the Kanaka Maoli religion, whose cosmology confirmed the ideology of spiritual rectitude affirmed by physical presents, had long been put aside, long-standing core beliefs did not die off so readily in the minds of the populace.

Without the support of the indigenous religion, those of the pivotal Ali'i class were no longer able to confirm for the populace their spiritual efficacy through ritual or manifestation. No longer could the masses turn to their leaders, assured that they stood in good stead with the Divine. The rampant spread of diseases and the massive die-off of the Kanaka Maori was a powerful message, a spiritual affirmation telling the indigenous people of the islands that their time on this plane of existence was in decline. Calvinist missionaries brought the religious concept of "original sin" to the islands. The presence of so much death and disease in their population could only confirm for the Kanaka Maoli that they had somehow offered offense to the Divine, were guilty of some great offense—a belief affirmed by the immigrant religion. As the royal leadership moved to embrace the new religion, the people could only follow suit in order to regain some measure of religious rectitude. This conversion to Christianity would in effect move many of the people closer to the new religious leaders and farther from their traditional chiefs as their temporal and spiritual loyalties were realigned.

LAND TENURE

Another social change factor unfolding during this period of time was introduction of the notion of land as a commodity, as something that could be owned by an individual. Like other high-context, aboriginal societies, individual Hawaiians drew upon their local environment for certain aspects of identity. Place names were actually clues or markers that were often about the ancestral antecedents of those living in the locality. For the ruling classes, limited-term stewardship of locations was a direct way to acknowledge their community responsibilities and social import. In the 19th Century, the island kingdom experienced dramatic changes in local practices concerning land tenure and ownership. Some of these changes came from within the native culture and others were motivated by colonial political and commercial pressures. The first of these changes came from the way some Ali'i families violated traditional protocols in the distribution of land stewardship at the death of Kamehameha Pai'ea. Eventually these concerns were intertwined with the imperialist interests of immigrant and foreign entities. In 1848 Kamehameha III decreed The Great Mahele, an edict enacted to resolve questions of land title being pressed by foreign

interests. While the decree was authored to provide property and economic stability for the indigenous population, in actuality the edict allowed the ownership of land among immigrants to increase so rapidly as to leave most of the indigenous population effectively landless. Unfamiliar with Western land title laws and procedures, many Maka'ainana class persons lost their opportunity to gain ownership of traditional lands. The Mahele allowed immigrant business interests to acquire and consolidate large tracts of plantation lands for agricultural markets in foreign ports. For the Ali'i leaders, many of whom were not allowed to assume tenure over lands at the death of a great chief, these changes meant they were unable to grow and develop in their responsibilities as community leaders. For the land-based Maka'ainana class, they became a displaced people, shifting from a largely agrarian lifestyle to an urban life, regardless of their needs or desires.

For a high-context oriented society, like that of pre-contact Hawaii, these changes in land tenure had significant and detrimental impacts on the self-identity of the Kanaka Maoli people, the echoes of which may still reverberate through the psyche of the modern Hawaiian community.

THE WAY IS WELL AND TRULY LOST

By the middle of the 18th Century most of the native population who had survived the initial onslaught of colonial diseases, found themselves in poor health and landless. By royal decree, conversion to Christianity and inundation by Western educational practices, the Kanaka Maoli population had been almost entirely stripped of the means for teaching and reinforcing traditional cultural values and practices; cultural norms and values used to establish a healthy indigenous self† identity. Within the span of one generation, they were dispossessed of their spiritual foundation and the ways for understanding of the intrinsic meaning of cultural norms that had sustained them for millennia. The Kanaka Maoli had even lost their traditional self-identifying name. By this time they were being called "Hawaiians" to fit with Westerns notions of geo-political naming for populations. Due to lack of an indigenous spiritual structure for guiding their maturation as Kanaka Maoli men or women in a modern world, this alteration of native identity remains in place to this day. At this point in history Hawaiian men, as warriors, as leaders, as beings, are almost entirely estranged from traditional sources that might guide them through the storm of cultural change that was the colonial movement of the last 225 years.

IV. IMPLICATIONS—HEALING THE WARRIOR

Cultural Healing—An Educational Process

For modern Kanaka Maoli men to make headway against the negative health status profile they currently epitomize, they must begin to feel worthy of basic goodness. In order that they avoid any comparison to earlier colonialist attempts to "civilize the savage", cultural healing interventions must not take on the methods or philosophy of a social rescue initiative—either for individuals or communities. A disenfranchised person does not benefit from a remedial approach that first requires them to accept an image of themselves as a victim of some larger power before allowing them to find their sense of personal power.

Healing through education is a use approach for improving the health of populations that have suffered the rigors of colonial oppression. Different than conventional health education initiatives, healing through education, especially for disenfranchised populations, brings into account cultural factors not found in curricula produced by government health agencies. Most health education efforts do not acknowledge the specific pedagogical or epistemological basis used in the construction of their approach to knowledge and human change. Molded by Western concepts of health and learning, the approach of such unexamined curricula can be posited as a direct form of cultural wounding, making them counter-productive in the effort to improve the self-image of indigenous populations seeking greater health and well-being.

Education for purposes of healing is a pedagogical construct largely missing from the traditions of Western education. Contemporary societies are more apt to separate the concerns of education and healing into discrete fields of discipline. In modern capitalist societies, the role of teacher is to pass along knowledge and information, largely bounded by the values of commercialism. In contrast, the role of healer is tasked with addressing the traumas of mind and body. The modern priest is the one most usually called upon to treat wounds of the soul. Separation of these roles and responsibilities is not as distinct in many indigenous populations—especially those who still live in a high-context orientation with regards to human and community development (Meyer, 2003, pp. 4–6). Division of an individual's life into dis-

crete, isolated compartments is in direct opposition to models of reality used by many environmentally centered, indigenous populations. Observation of the natural environment has led them to a philosophical structure that is inherently interdisciplinary.

Education for healing is a pedagogical approach which accepts a philosophical position that the processes and goals of education are to move the individual and the collective learning community beyond knowledge and information, entering the province of wisdom, in both intention and practice. For many people education is the acquisition of knowledge. In contrast the pedagogy of healing education targets wisdom and is therefore concerned with the production of meaning in the lives of learners. In the development of wisdom it is necessary to learn to constructively embrace the wounds of life. Traumas are examined to reveal process. Pain is uncovered to show the interconnected contributions each party may have furnished to the pain felt, and each person's responsibilities to the collective journey of healing. This process of examination is undertaken to allow the dynamics of relationship to be revealed. Being thus informed, armed with insight and wisdom, a person can grow to move more confidently into an uncertain future.

KANAKA MAOLI HEALING PROCESSES

The process of educational healing for Kanaka Maoli men is of necessity an initiative that must acknowledge the importance of cultural renewal. Present-day Hawaiian men are learning to recognize and reclaim the value of the Maoli philosophy—an indigenous epistemology based in a meticulous cosmology common to native people throughout the Pacific. It will be through the Ano, moral integrity of their Kupuna, wise Ancestors, that these men will once more reclaim their right to the ways of healthy living. The 'lhi Kapu, the Sacred Law was what kept countless generations of Kanaka Maoli whole and healthy during their great migrations across the Pacific. Far from being a pre-colonial anachronism, the Kapu retains capacities which may be used to assist modern Hawaiian men in regaining their selfhood in the world.

The ultimate aim of educational healing is to free people from fear, shame, and doubt. As Hawaiian men come to understand the circumstances and forces influencing their lives, they will be afforded access to knowledge about cultural dynamics that have led them to a negative sense of self-worth. Awareness of these multigenerational influences holds the potential to free them from the cycles of suffering that have constrained their power. In the pedagogy of education for healing, forgiveness is a key quality—forgiveness for self and for others. Eventually, through engaging in many cycles of insight, forgiveness and wisdom, a person or community can develop options for living a healthy and powerful life. Options are freedom. Freedom allows for graciousness and peace to emerge.

WARRIOR CULTURE AS HEALING AGENT

Almost paradoxically, the way to healing for Kanaka Maoli males as warriors lies in the world of warriorship. Traditionally, for Asian and Pacific peoples, war-making skills were counterbalanced by strict and demanding social and spiritual obligations. Recognizing the trauma for all parties due to the expression of their vocation, indigenous warrior societies integrated healing traditions and cleansing rituals into their human and warrior development practices.

In most instances, cultural definitions of the warrior self are constrained to associations with violence and death. In Asia and Polynesia, where native philosophical constructs require the harmonious balance of opposites, the warrior archetype is as much a figure for the generation of life as it is for death. In the Japanese warrior traditions of Budo, two images are contrasted: Satsujinto, the sword that gives death, and Katsujinken, the sword that gives life. For the Kanaka Maoli there were corresponding structures allowing for differentiation between warrior intentions leading to death, and those that were associated with healing and life-giving: Lawe Ola, death without conscience, and, Malu Ola, a tradition that safeguards life. Also, in the Kanaka Maoli pantheon of deities, the male entity Ku is most often associated with war. Among his more than seventy named aspects includes Kuka'ilimoku, the Island Snatcher. He also encompasses Kukapono, the Beneficent; Kukaloa'a, the life giver; Kukaha'awi, the Bestower; and Kukepa'a, the Steadfast. The Kanaka Maoli a warrior could only be true accord with his warrior self if his vocation balanced the war making with the generating of life.

An inherent obligation for the pre-contact Kanaka Maoli warrior was to enter the ways of ritual practice to balance the pain of violence with the relief of healing practices. Unfortunately, many of these skills and obligations were largely set aside as colonial powers swept into the region. Warrior-healing values, and their associated

ritual/educational systems, represent native forms of healing education. If properly revived, these values and practices may once again be useful in serving Hawaiian men who wish to orient their lives to traditional Maoli ways.

SANCTUARIES FOR MOURNING AND RE-ENTRY

In pre-contact Kanaka Maoli's society specific locations were designated for rituals to expiate the stains of war. These sites allowed returning fighters to be cleansed of the emotional and spiritual profanity taken on in battle before reentering the society at large. Setting aside a period between the battle and reentry into common society is a critical interval for initiation of a warrior's healing. Some form of considered re-entry into civil society is common to many indigenous warrior societies. Before the age of modern air travel, armies were allowed a period of transitional grace on the long walks home, and then on ships. This allowed soldiers to adjust from the rigors of war before again entering the measured pace of civilian life. During periods of reentry it is possible for the psychological and spiritual processes of cleansing to proceed with a rhythm of graciousness. Storytelling, bouts of celebration, times to laugh and cry, all are ways veterans use to begin the cleansing needed to assist their return to normative society.

In pre-contact Hawaii, Pu'uhonua, places of refuge, and Heiau, the temples, were locations where such reentry work would originate. In part, these sanctified places were used to affirmation of a person's sense of responsibility for their contribution to social decency. These locations allowed the Kanaka Maoli warrior to proceed into normal life cleansed and free from guilt—reborn to a settled conscience. The places of refuge and temples were in essence the Eternal Womb, a symbolic location from which warriors could reemerge cleansed of the taint of death, sacrifice, and metaphysical trauma. They were places for spiritually rebirthing Kanaka Maoli warriors to normalcy. Such places of healing and wisdom are echoed in the halls of educational institutions and in the treatment rooms of healers. Unfortunately, nowhere in present-day Hawaii is there a consistent place for modern Kanaka Maoli men to gather to integrate healing lessons in the manner of their ancestors.

V. WALKING THE HEALING PATH

For substantial change in the health status of the present population of Hawaiian males, it will be necessary to understand the nature of the violation of self embodied in the hearts of modern Hawaiian men over the last 225 years. Only when the scope and scale of the malaise filling their hearts and minds is understood and accepted will Western health care professionals and policymakers be able to support a culturally appropriate return to health and well-being. Using the structure of Cultural Trauma Syndrome, research into the processes of pain and injury felt by Hawaiian men is already opening the way to a greater understanding of the scope and scale of their cultural wounding. Ultimately the task of healing must be motivated, controlled, and activated by these men themselves—no one can fully heal another without leadership from those to be healed.

Modern Hawaiian men need to regain a sense of cultural wholeness missing since the abrogation of the sacred laws in 1819; a loss of selfhood exacerbated by many forces in the colonial period. Their healing must be supported by the psychological, social, and spiritual elements of ritual cleansing and rebirth. The progress of cultural healing and renewal will set a healthy social and spiritual precedence for modern Hawaiian men to adhere to in their lives. The presence of a viable structure of moral regulations and guiding values is necessary to support the indigenous men of Hawaii on a journey of self-healing.

The road to recover may take many generations to complete, but what great task is ever easy? The reason for undertaking such an arduous task is simple; to not do it means to die—as men, as a people.

"'A mama,' Ua noa."

"It is complete. It is free."

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KANAKA MAOLI MEN: CHANGES IN STATION, CHANGES IN HEALTH

Draft Chapter for "Hawaiian Culture and Health" Ben Young, M.D., Editor
Bud Pomaika'i Cook, Ph.D., and Lucia Tarallo-Jensen

This was a great people at the beginning. It filled the Hawaiian group. A people with clean body, large-limbed and strong, a little less than the lion in strength, long-lived on the earth. A lovable people, amiable kindhearted, hospitable to strangers . . . Such is the character of the Hawaiian people. Kepelino [1]

INTRODUCTION—THE CONTRAST

When European explorers first arrived on the shores of Ka Pae Aina, modern Hawaii, they found a vigorous society and a healthy indigenous population. In their physical well-being the Kanaka Maoli [2] living in the islands embodied almost an Aristotelian ideal of physiological health and beauty. The vibrancy of their physical condition was echoed by the elevated state of development of their intellectual and material property. Drawings from these first expeditions show a vibrant people, living in beautiful communities, bounded by agricultural and fishing industries supporting a large population.

In the next one hundred years, changes more devastating than could be imagined were to take an immeasurable toll on the Kanaka Maoli. Imagine living in a cultural group where: ninety percent of the population die; the religious structure that has sustained the community for hundreds of generations is erased by a local elite and replaced by a foreign system of beliefs; the approach to government used for thousands of years is replaced by an imported government put in place at the point of a gun; and, the indigenous forms of economy that have brought sustainable but

equitable prosperity to the community are wiped away, all within the span of a single century. Is it hard to imagine that the survivors of a trauma event of this magnitude would be rocked to their core and would show effects from this insult for generations to come?

KANAKA MAOLI MEN'S HEALTH

These Indians, in general, are above the middle size, strong, and well made, and of dark copper colour, and are, on the whole, a fine handsome set of people. Beaglehole [3]

The descendants of the Kanaka Maoli, modern day Native Hawaiians, cannot make claims to health status like that described by Beaglehole and his peers. The health status indicators for Native Hawaiian men are a dire recitation of poor health statistics. Native Hawaiian men are disproportionately represented in almost all areas of risk for increased morbidity and early mortality. Although census data indicates that Native Hawaiians are a growing segment of the population, what is not shown is just how those people suffer from the aftermath of cultural trauma events that echo from the arrival of Cook in 1778 to the present time. For Native Hawaiian males this burden of trauma has been especially exacting. The statistical bottom line for health may be found in how long a person is expected to live, and in this instance Native Hawaiian males are the clear losers. On average, a Native Hawaiian male will die 6 years earlier than the average for all other male populations, and almost 16 years younger than the average for all women. Hawaii State Department of Health [4]

CULTURAL TRAUMA SYNDROME

No matter their racial origins or places of residence, the health statistics for disenfranchised cultural populations is distressingly similar across the United States. Similarities in negative health status support the assumption that neither environment nor genetics are the likely factors driving these declines in well-being. Searching for additional perspectives to explain these circumstances, in 2004, Cook, Withy, and Tarallo-Jensen proposed a culturally driven model for describing the development of poor health in these populations—Cultural Trauma Syndrome, (CTS). This condition is recognized by an interdependent set of social and cultural patterns. As an operant social change theory it accounts for people born into particular cultural groupings and to those persons who, though they may not share a genetic link to the history of a cultural faction, are people whose personal identity is inextricably tied to the specified group.

1. This injury is a process of cultural genocide. Targets cosmology, epistemology, pedagogy, and social structures as objects for repression.

It is not necessarily linked to declines in population. Rapid declines in cultural population numbers, however, usually correspond with actions of cultural assault.

2. Attacks on indigenous social norms bring breakdowns in many normative cultural social structures.

Breakdowns occur in traditional religious and spiritual boundaries, forms of community leadership, family configurations, and gender specific social roles.

Lack of continuity and understanding of traditional social structures slows cultural renewal.

3. Trauma related events and perceptions of their intensity do not, by necessity, have temporal continuity.

What may not have been felt as injurious by one generation of a population may be experienced as an offense by later generations.

Cycles of severity may correspond to modifications in political efficacy.

4. Sources for injury may come from within, as well as from outside a defined cultural group.

Disenfranchised individuals and sub-groups take on the role of perpetrator of cultural wounds as an adjunct to violations originating from outside the cultural group.

Internal divisiveness reduces advocacy for healthy relationships with other cultural groups.

5. Incidents of traumatization have inter-generational transference.

The mechanisms of Cultural Wounding keep the insult of a trauma event activated across time.

Insults may remain dormant for long periods of time, only to be rejuvenated by recent events.

Cultural Trauma Syndrome can be recognized by a pattern of circumstances in the cultural group. Because this is a cultural disorder, individual, family, and community patterns of dysfunction must be shown for this condition to be identified as a causal factor.

Individual

1. Cannot maintain intimate, mutually constructive relationships
2. Cannot trust or be trusted
3. Cannot persevere when difficulties arise
4. Cannot function as a constructive parental role model
5. Cannot hold a steady job
6. Cannot leave behind harmful habits leading to Suicide-by-Lifestyle

Families

7. The family serves as a generator of dysfunction
8. Patterns of addiction and abuse are passed on
9. The family is no longer able to provide the foundation for healthy community life
10. The family perpetuates connections to traumas of the past

Communities

11. Rampant backbiting and internal strife
12. Internal separation of cultural identity, "traditionals" vs. "moderns"
13. A tendency to pull down the good work of anyone who rises to serve the community
14. Political corruption
15. Lack of accountability and transparency in government
16. Chronic inability to unite and work together to solve shared, critical human problems
17. Widespread suspicion and mistrust between people
18. Competition and "turf wars" between programs
19. A general disengagement from community affairs by most people
20. A climate of fear and intimidation surrounding those who hold power
21. A general lack of progress and success in community initiatives

Cultural Trauma Syndrome manifests itself in a variety of ways. Small but distinct differences are evident for cultures showing variations in social history. The ways people are removed from their cultural identity, practices, and values has implications for how their course of recovery needs to proceed. While not an all inclusive description for how all people from any one cultural group are tied to their cultural history in the United States, the five key cultural trauma variation

Categories under study are:

a. Populations that were brought to the United States as slaves, and were stripped of all association with their root culture (i.e., African American);

b. High-context cultural populations that were conquered and removed from their ancestral lands (i.e., Native Americans);

c. High-context cultural populations that were conquered but allowed to remain on or near ancestral lands, but with no traditional rights to access, ownership, or control (i.e., Native Hawaiians, Native Alaskans);

d. Populations that immigrated to another country, voluntarily or not, and were pressured to assimilate with the new dominate culture (i.e. European Americans);

e. Populations that immigrated to another country but were allowed to maintain enclaves of cultural associations with others from their home culture, even in the face of other disenfranchising forces from the dominate host culture (i.e., Chinese Americans, Japanese Americans).

Addressing the challenge of cultural trauma is a complex matter. Any person or group of people identifying with the social and cultural history of a disenfranchised culture is at risk for being impacted by the abuse offered to the generations of that culture. Even more poorly understood is how people of mixed cultural origins are influenced by the complex of social histories they bring together in their diverse heritage. What is understood is that the resolution for this problem requires the involvement of the whole community, and calls for the combined efforts of experts from outside under the leadership of members of the effected community.

KULEANA—THE REALM OF MEN'S RESPONSIBILITY

In order to more fully comprehend the challenges facing Native Hawaiian men in this modern age, it is necessary to have an understanding of their pre-contact realm of responsibility. The primary issue for any pre-contact Kanaka Maoli male seeking to be an upright person would have been the cultivation and protection of his Ano—the seed of moral integrity. This essence was the spark of divinity residing within any Maoli—true, person. A celestial characteristic is inherent to the indigenous self-identity held by all Maoli people of the Pacific region. The Ano was a quality that pre-contact Kanaka Maoli fostered through carefully planned marriages, religious rituals, and, proper and fitting behavior at all times.

The way to realization for one's Ano was through strict observance of the 'lhi Kapu—the system of sacred statues. This system of consecrated laws enabled a people to live in harmony with one another, with nature, and with the spiritual realm of their ancestors. Living in accord with this system of laws was what defined a person as Maoli—as true and genuine. The Kanaka Maoli male's held a position of social and religious leadership for specific responsibilities of the 'lhi Kapu. From conducting major state rituals to small daily observances for deities under his care, the Kanaka Maoli male social role was central to maintenance of the kapu—protected, aspects of the society. The kapu was a central control over hygiene, environmental policy, land tenure, family concerns; almost every aspect of healthy social and personal functioning. Both genders carried special responsibilities. It was the male's kuleana—honored responsibility, to serve as a shield between the community and harm—temporal and spiritual. Almost every area of exclusive social responsibility tied to Kanaka Maoli men was lost in the colonial period.[5] The loss of social responsibility has contributed to a loss of personal identity for many Native Hawaiian men and has left them adrift from the healthy ways that would foster well-being in their minds, bodies, and spirits.

RELIGION AND GOVERNMENT

Until 1819 and the abrogation of the tradition system of religion by a small ruling elite, men carried the bulk of the responsibility for religious leadership. Religious leadership was intertwined with other social responsibilities involved with economic, diplomacy, and the rule of government. Kanaka Maoli society did not fit with the strict definition of a theocracy; the rule of government was not held by' an elite group of priests. It was, however, clearly a religion-centered system of government whereby the Ali'i Nui, principal leaders, mediated the interchange between the celestial and terrestrial realms, the mundane and the divine worlds, all orchestrated by the Kahuna Nui, primary priest. The Kahuna Nui was set in place to make sure that thousands of years of sacred laws were upheld, made sure the Ali'i under their charge followed the code of behavior required by the 'lhi Kapu. Proper observation of an annual schedule of religious ritual and responsibilities was integral to the functioning of the society. Some observations were less grand; each day in the Hale Mua, the men's eating house, a small image of Lono with a gourd attached was kept where an offering of food was deposited by the men. The elemental aspect of Lono shared in the men's daily meal; by being given the first bite of food he was made manifest. The annual progress of social and community events was bounded by a series of local and state rituals designed to keep the society on a proper course of development. Temporal and spiritual authority worked in cooperation to bring about healthy and prosperous conditions in this and the metaphysical worlds.

The political mandate of the colonial European and American movement was accompanied by a corresponding command for religious dominance in the newly claimed territories. The competition between Protestant and Catholic religiopolitical forces was played out in Hawaii as it was in other parts of the Pacific region. In spite of the fact that the first recorded baptism of a Native Hawaiian was in 1819 by a Catholic priest, it was the Protestant sects that were the most influential in early efforts to convert the island population to Christianity. In 1820, several months after orders declaring the heiau, temples, be torn down, Calvinist Missionaries landed on the island of Hawaii and were granted permission to preach and proselytize. Acceptance of the religious message of these first missionaries was assured wide acceptance when key Ali'i took up their cause. The need for a religious base in a culture that had always paired religious and secular power was a critical gap left by the abrogation of the native religion. The coincidental arrival of Protestant missionaries filled this critical gap for the ruling elite and their agenda for consolidating rule. Unfortunately, certain aspects of Protestant philosophy and dogma led Native Hawaiian men further from their traditional place of personal power, one grounded in observing proper relationships with their ancestors.

The first Protestant wave breaking on the shores of Hawaii was led by members of New England Calvinist missionary sects. Calvinism is set up on three basic principles Bowker,[6] the first two of which resonated with the Kanaka Maoli vision of creation. The third of these provided a crashing blow to the emerging Native Hawaiian image of self:

1. Supremacy of scripture as the sole rule of faith and practice.

The Kanaka Maoli held to their religious traditions as passed down through a rigid and precise tradition of oral transmission. These oral traditions were watched over by Hale Naua, a social institution founded by the Maui Island chief Haho in the eleventh century to contain the genealogies and protocols of the nation.

2. An authority confirmed by the inward witness of the Holy Spirit.

The Kanaka Maoli affirmed the authenticity of this inward witness by noting its correspondence with their Wailua—the Soul Cluster: the ʻUhane—the conscious soul that speaks; the ʻUnihipili—the subconscious soul that clings; and, the Aumakua—the super conscious parent that hovers. The Wailua was seen in pragmatic effects, was affirmed by the outcomes it brought into the world.

3. Men and women were inherently sinful, lost in iniquity, and could only be delivered by the Bible's message.

Kanaka Maoli cosmology has no concept paralleling to the Christian idea of "original sin." The proposal that a child was born hewa—profaned by sin, from birth was a new and sad reality to accept. Because the Kanaka Maoli did however believe in redemption through acts, the presence of the Bible as a means for release from sin was a powerful tool wielded by the Missionaries for controlling the behavior of the locals, keeping the savage natives in line with social ideals they endorsed.

WAR

Men were not the sole purveyors of war activity; Kanaka Maoli women did sometimes accompany their men into battle, sometimes in a combat support role, and at times as combatants with their own traditions of war-fighting. As is true for most societies, however, Kanaka Maoli men carried the lion's share of responsibility for entering the profaning realm of shedding blood. Until the era of final conquest by Kamehameha Pai'ea in the late-eighteenth century, war making in Hawaii was a highly ritualized affair. Great care was taken to contain the horrid stain of violence unleashed by battle. Non-combatants, food growing areas, and religious sites were noted and cared for in pre-battle negotiations. It was not only important to be victorious in battle, but also be pono—principled and moral, as well. Because all Kanaka Maoli activities took on both temporal and spiritual responsibilities, it would be possible to win the earthly battle and lose the moral war. For example at the end of his massive campaign of inter-island war, Kamehameha Pai'ea took up a series of civil engineering projects, building temples, fishponds, and taro fields. These projects and the rituals that accompanied them were designed, in part, to expiate the burden of spiritual contamination built up during his campaign of conquest.

Kanaka Maoli men engaged in considered practices to safeguard themselves from spiritual pollution in war through specific ceremonial practices. In these rituals the elemental portion of the Wai Lua, the Uhane, was placed in safekeeping in the complex of heiau used to consecrate the war effort. After battle, in the Hale 0 Papa, the women's heiau dedicated to the Divine Female through her representation as Haumea or Papa, the male Moʻo Ku, would conduct a ceremony by which the warriors would be ritually reborn through the women of the ʻOiwi, clan. This ceremony returned the warrior's Uhane from its respite, safeguarded from the stain of conflict. While the male priests of the Moʻo Ku would orchestrate this elegant ceremony, it was through the female space that Kanaka Maoli warriors would be reborn to their civil earthly self. The ʻUnihipili as reborn with a fresh start reunited with the ʻUhane, repeating the warrior's first birth into the physical world.

Once the indigenous religion was removed in 1819, all supports allowing men to redeem themselves from transgressions of ʻlhi Kapu vanished. No longer did the warriors have a place to go to make themselves safe in the conduct of their vocation. The Puʻuhonua—sanctuaries and places of refuge, that allowed the Kanaka Maoli to expiate the transgressions of the kapu were left without the requisite spiritual foundation to be effective for the people. Kanaka Maoli men now had no foundation of support to deal with the emotions of anger and violence that might well up in them. The loss of constraint provided by the ʻlhi Kapu meant that all forms of public and domestic violence now could only be resolved through punishment. Gone forever were the systems of healing education that required violent men to grow and develop to show they could be trusted to once again enter civil society. All that was left to address male violence was jails and even more death—a legacy of judgment that continues today with Native Hawaiian men being overrepresented in prison populations.

OTHER SOCIAL LOSSES

In addition to the loss of the supporting structure of the ʻlhi Kapu, almost every other formation required for healthy identity was also changed in traumatic ways for the Kanaka Maoli community. In less than one hundred years an estimated ninety percent of the pre-contact Native Hawaiian population died. The Kanaka Maoli approach to education based on oral transmission between a master of knowledge and a selected disciple was supplanted by Royal decree with Western text-based knowledge. The customs of Kanaka Maoli marriage were careful alignments

of genealogical relations became marriages of economic convenience, with Western traders marrying Hawaiian women for the social benefits they might provide. These benefits included the opportunity to become citizens of the kingdom, which then allowed these immigrants to purchase and sell lands. The collaborations of families arising from shared social and genetic histories were replaced by arrangements of economic advantage. Once the Federal Hawaiian Homes Commission Act was made into law in the 1920's many of the descendents of these unions were legally disenfranchised from their identity as Native Hawaiians, all because they did not meet the regulatory requirement that they be of fifty percent Native blood quantum. Marriages that at one time were sought because they provided distinct economic advantages now served to distance people of insufficient blood quantum from their island-based cultural heritage. The Kanaka Maoli approach to communal wealth, a system that tied religious and social development to the production of shared prosperity, was supplanted by Western capitalism, a system that reduced economic benefit primarily to the shareholders of the corporate entity. Finally, in this same short span of history Native Hawaiians were asked to adapt their sense of community leadership from a ruling Ali'i born with a divine mandate to care for the lands and people, to a constitutional republic founded on democratic principles that "all men were created equal." Unfortunately, as the historical record clearly demonstrates, once American and European interests forcible took over the government of the islands in 1893, Native Hawaiians and their indigenous culture were consistently treated as less-then-equal in almost every social arena.

Few modern societies have experienced shifts in social structure as dramatic as those forced upon the Hawaiian society starting with the arrival of European explorers in 1778. The list of tortuous changes to local social support structures cast many Native Hawaiian men adrift, left them with no clear social role to fulfill in sustaining their families through the change required by Western colonialism as it spread through their island's cultural milieu. The elaborate complex of psychology and spiritual supports required to afford a person the skills needed to form a clear and coherent expression of social culture were unavailable to many Native Hawaiian men, and remained unavailable for several generations. Accommodating for losses and changes due to the influx of colonial power was not something Native Hawaiian community leaders took into account when taking on new technologies and cultural values. These leaders were not alone in their naivet; the process of community grieving for changes to long-held social and cultural traditions is not well understood in even in today's world. How people come to some level of accommodation to new forms of social standards and practices was not a concern for Native Hawaiian or Western leaders as they instituted massive changes in the social norms in the nineteenth and twentieth centuries. The many ways these changes influenced the society could not have been foreseen. Perspective on how the Kanaka Maoli world view was changed and the demands these alterations made on the resident population is something modern community activists can take into account in their cultural restoration endeavors.

HEALING

The last two hundred and thirty years have been some of the darkest times in recorded history for the Kanaka Maoli. This has been a period of darkness and death. Another way to look upon this period of social change, however, is that it has also been a time for the true strength of the Kanaka Maoli character to show its usefulness in the context of the world cultural setting. The Kanaka Maoli have always adapted to bring about changes in their worldly circumstance. Skills that served their ancestors to bring environmental prosperity to barren island ecosystems may now be brought to bear to bring this time of great death to a close. In essence the Native Hawaiian people have moved from a time of Lawe Ola, death without conscience, to one of Malu Ola, the traditions that safeguard life.

In the last quarter of the twentieth century a new sense of Hawaiian culture began to emerge. Moving away from culture as a support for the tourist industry, Native Hawaiians began to explore the knowledge and wisdom of their ancestors as a way to address a need for cultural identity. One of the first successful efforts came in 1975 when the Hokule'a, the first contemporary double hulled canoe built for long distant ocean voyages using traditional navigation methods was built. At present the building of canoes and revival of traditional star navigation techniques has become a Pan-Pacific phenomena; bringing hope for continued recovery of culture to indigenous peoples throughout the region. Following on from the massive amounts of information generated by the voyaging canoes, a companion effort to place Native Hawaiian knowledge and values at the center of education gained momentum. Another group emerged simultaneously with the Polynesian Voyaging Society. Hale

Naua Ill, Society of Hawaiian Arts under the directorship of Rocky K. Jensen had their first fine arts exhibition on the very day the Hokule'a landed in Tahiti. Bringing to the forefront an esoteric awareness of the indigenous culture, the Native Hawaiian artists sought to create from a spiritual place, allowing for the energy to flow through a Piko, the spiritual and physical umbilicus, that was still connected to the cosmogonic Ancestors. Building schools and institutions of higher learning centered in the Hawaiian language and culture found renewed vigor in the mid-1980's. These schools have now become the vanguard of a massive social change movement. These efforts show that political awareness paired with considered education and training can bring about substantive social reform. The path of healing from cultural trauma for Native Hawaiian men lies in education; a path of knowledge that leads to the redevelopment of the Loina Kane, the song of male origins, values and ideals found in the ancestral ways of the 'Ihi Kapu.

The aim of any effort of cultural healing is to afford an individual or a community the opportunity to recapture their Ano, their seed of moral integrity. These reconciliation and restoration efforts must provide verifiable and culturally centered means for increasing the substance of person's honor and respectability.

For all the efforts made in the last few decades in cultural recovery by the Hawaiian community, the one element missing is revival of an indigenous approach to the Kanaka Maoli esoteric life. The Kanaka Maoli visualization of human reality included interplay of corporeal and spiritual elements. The physical needs of the body were paralleled with the psychic and spiritual needs. Native forms of rehabilitation included skills attuned to the needs of the body, mind, spirit, and the collective of the community. The Kanaka Maoli knew the importance of punishment and redemption as attendant means for addressing transgressions of community norms. In many cases there was a concerted effort made to allow the individual an opportunity to make things right. Prayers, sacrifices, and rituals of redemption could bring the transgressing individual back to a place of spiritual and temporal wholeness. Places for these activities were the Pu'uhonua, permanent sanctuaries that dotted the islands. The dedication to safety and redemption was evident in the way the Kanaka Maoli made places of refuge available. For example, during battle a specified location or a prominent person could be designated as Pu'uhonua, providing a warriors and non-combatants a place of refuge from the chaos of violence for those who could reach these precincts.

Native Hawaiian men have been traditionally overrepresented in the jails and prisons. While Native Hawaiians comprise about twenty percent of the general population, they represent forty-four percent of the in-state prison population. Office of Hawaiian Affairs.[7] Loss of rituals for redemption, loss of locations where a person can redeem their sacred honor makes jails all the more needful. Loss of sacred spaces where a Native Hawaiian man can be trained in the Ano of his ancestors, in the character and workings of a healthy human being, makes it unlikely that a person's behavior will rise any higher than that needed to avoid punishment. Since the arrival of Western religious and political ideals the primary seat for this authority has been removed from the prevue of the individual and their closely held community, and given to the judgment of an externally-located authority—judges and ministers.

For Native Hawaiian men to come to a satisfactory cultural vision of a healthy male role, they will first have to come to an accommodation with the confusing range of voices that tug at their heart, mind, and spirit for attention. From the failure of the Colonial effort to reshape the Native Hawaiian consciousness into some echo of itself it is possible to say that this method is not the means the community should use to change the negative health and social indicators now describing the population of Native Hawaiian males. The effort of cultural recovery cannot be an adversarial undertaking. The solution to the Native Hawaiian males circumstance cannot be an "either/or" enterprise. There is no need for these men to try to be either a pre-contact Kanaka Maoli, or a fully assimilated Westerner. For thousands of years the Kanaka Maoli adapted their knowledge to suit the needs of their community. The resolution of the present circumstance of cultural trauma cannot subscribe to a rigid plan. Remediation of this trauma will pair insight with fortitude. The way to health for Native Hawaiian men lies in molding the best of education and healing to suit the needs of individuals and their communities. Echoing this call for remaining adaptable when charting a course for cultural healing, after twenty 5 years of study, the Canadian Federal Government came to the conclusion:

> . . . healing means moving beyond hurt, pain, disease, and dysfunction to establishing new patterns of living that produce sustainable well-being.
> Aboriginal Corrections Policy Unit[8]

The community of Native Hawaiian men will need to embark on a voyage of discovery; this time seeking the horizons for a place of wholeness, rather than of new lands. For this place to be sustainable it will have to find a way to assist them in bridging pre-contact values, beliefs and practices over to the present era. This will not be a project of assimilation into the Western culture, nor will it be a return to the pure ways of their forefathers, but will be something drawing from the best each has to offer. Because the Kanaka Maoli culture is one of entwined powers, for this journey to be at last healthy it will have to include the needs of the women of this community.

Sustainable well-being is the goal. The time for the unending loss of life and vitality from the last 228 years—losses to the land, people, and culture—must now come to an end. Replacing the systems of conflict and indoctrination inherent to the colonial mind set must be Maoli systems, structures that honor the deep truth that arises from respect between cultures. Native Hawaiian men must once more be allowed the respect to renew their alignment with Loina Kane—their song of origin.

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[1]Kepelino, (1974). Traditions of Hawaii, Bulletin Bishop Museum Press, Honolulu, HI, p. 74.

[2]The designation "Kanaka Maoli" will be used to identify members of the indigenous population in what is known today as Hawaii from pre-contact to 1819 when the aboriginal religion was dismantled. The designation "Native Hawaiian" will be used to designate all persons of this group from 1819 to the present.

[3]Beaglehole, JH. (1967). "Samwell's Journal—The Journals of Captain James Cook." New York, NY., p. 178.

[4]Hawaii State Department of Health, Honolulu, HI, Behavioral Risk Factor Surveillance System, Retrieved June 10, 2005 from the World Wide Web: *www.hawaii.gov/health/statistics/brfss2002/bffssO2.html*.

[5]The term "Colonial Period" will designate the period starting at the arrival of the English explorer Capt. James Cook in 1778 to the present.

[6]Bowker, J. ed. (1997). "The Oxford Dictionary of World Religions. New York, NY. Oxford University Press, p. 190.

[7]Office of Hawaiian Affairs (2002). Native Hawaiian Data Book, Retrieved May 26, 2005 from the World Wide Web: *www.oha.org/pdf/databook602.pdf*.

[8]Aboriginal Corrections Policy Unit. (2002). Mapping the Healing Journey: Final Report of a First Nation Research Project on Healing Aboriginal Communities, Solicitor General of Canada and the Aboriginal Healing Foundation, p. 12.

PREPARED STATEMENT OF GUY POULIN

I am submitting the following written comments to the Senate Committee on Veterans Affairs which is meeting in Hilo on January 13, 2006. Since the public will not be able to make oral statements, I am submitting the following comments.

I recently wrote to Senator Akaka to complain of some of the problems I have been experiencing at the Hilo PC Clinic. You forwarded my complaints to the VA and the VA's response to your inquiry, which you forwarded to me, was not accurate, but, filled with numerous inconsistencies and errors. My previous complaints were given in a brief form which the V.A. has used to spin into fiction to make themselves look good. This leaves me to explain in detail, the correct facts. These explanations of the facts are stated later in this letter. I will begin with several problems (and their brief detail) which I hope the Senate Committee will be able to address and solve.

First of all, here is my brief history with the Hilo PCC clinic. I received my full 100 percent Service Connected Disability in March of 2005, with this 100 percent disability being retroactive: from February 1999. All my disabilities are Physical Disabilities. I began going to the VA Clinic in Hilo, on a regular bases, around 1995. At the time, all the doctors at the clinic were either in private practice and only at the clinic part-time or, the doctors would come to Hilo from Tripler. I can't recall any major problems with these doctors. The only problem at the clinic was that patients would have to usually wait about 1 hour to see the doctor, but, this was because the doctors would not "shove us out the door". They would take their time to discuss any problems we were having. Oh, and the doctors had to hand write all their reports.

But with this "new" VA PCC, and its 2 full-time doctors, there are a number of problems. A few of the Chief Complaints are:

1. The doctors at the Hilo PC Clinic refuse to treat or listen to patients. I was Dr. Reviera's patient when he first came to the clinic. I was at 50 percent SC at the time. (However, Social Security had determined that I was 100 percent, totally

disabled in 1995.) Dr. Reviera refused to treat me for any condition that I was not receiving "monetary compensation for". For example, at the time, one of my disabilities was rated as: "2nd Degree Burns—0 percent." Dr. Reviera insisted that this meant that I did not have 2nd Degree Burns and he refused to treat me for the severe sensitivity I was experiencing. He would not listen when I explained that the rating meant the VA recognized my 2nd Degree Burns but would not give me any monetary compensation for it. Another time, my right arm (which had broken while I was in the service) was extremely painful and my arm and my right hand had swelled up. Dr. Reviera refused to do anything because my arm and hand were not listed as being service connected. I tried to explain to him that because I was at 50 percent SC, he could treat me for anything, whether they were recognized as being service connected or not. After refusing to treat me for months, (all my conditions were getting worse but he would do nothing new to treat me), he offered to refer me to a Pain Specialist, Dr. Park. Well, I went to Dr. Park who changed my medication and tried new treatments, such as acupuncture and nerve blocks. Dr. Park's treatments were welcomed and I finally felt some relief. I also switched from Dr. Reviera to Dr. Garrigan. About a year later, Dr. Garrigan referred me to an Arthritis Specialist, Dr. Uramoto who began treating me. Whenever I saw Dr. Garrigan, she was always forgetting about things that had been discussed at our previous visit. Many times she would deny something, but, luckily for me, she had previously put them in my records. When I went for my January 2005 appointment, I showed her the bulge near my naval. It was very noticeable and painful. She just looked at it and didn't do anything other than hurry me out the door. She kept saying she was late, but, I had only been with her for about 5 minutes and midway through this visit, she had sent me outside while she used the phone for about 20 minutes. I had to go to a private doctor who referred me to a surgeon who did the surgery on me.

2. Dr. Garrigan has no compassion for patients. Dr. Garrigan stopped me suddenly, with no regards to any withdrawal of medications which I had been on for years. (Note: A compete explanation of this situation is described later in this letter when I respond to the VA letter you forwarded to me.). There was also another time when Dr. Garrigan "messed up" my medication. For about 10 years, the VA has prescribed me a medication which contains "acetaminophen". In July 2004, I received my medication but it was different—it did not contain "acetaminophen". I called the Hilo VA clinic and talked to Dr. Garrigan's nurse. She said that I should just go to the drug store and buy my own Tylenol. I told her, "I thought I was suppose to have free medical." The nurse just laughed. When I called to renew my meds in August, I reminded the nurse of the previous month's error. She said she would get it corrected. Well, the wrong medication came again. When I saw Dr. Garrigan on September 1, 2004 and brought it up to her. She said she didn't know why the mistake had happened, but, Dr. Garrigan said that she was correcting it and the next prescription should be correct. Meanwhile, Dr. Garrigan said that I could just pick-up the acetaminophen "over the counter". Well, Dr. Garrigan did not make the correction as she claimed. The September and October prescriptions were still wrong. I was finally able to have it corrected in November of 2004.

3. Dr. Garrigan does not know her patients. In the last 2½ years, Dr. Garrigan has called me at my home, at least 4 times, claiming that I had called and asked her to prescribe me with certain medications. I never called her nor had I even heard of the medications. At the time that she claimed I had made 3 of the calls, I was being treated by Dr. Park and whenever Dr. Park changed medication, Dr. Park did it right on the computer while I was in her office. And, the last time Dr. Garrigan called me, I had just walked into my house, returning from Kona where I had spent the last 7 days and, I hadn't used a phone the entire time. She must have confused me with other Veterans. Also, whenever I go to an appointment with her, it seems she has forgotten most of what was discussed at the previous appointment.

4. Hilo PCC entering wrong information in my medical records. I have found numerous, wrong information entered in my VA Hilo PCC medical records. Earlier today, I had an appointment with a Specialist from Honolulu regarding having a colon screening. (Since I made 50 years of age in March on this year, I had asked Dr. Garrigan in August, about having a colon test because I had received a notice from my personal Medical Insurance, HMSA, recommending that this test be run when a person reaches 50 years old.) The nurse who was interviewing me for the colon exam, said my VA records stated that I had a "history of problems with my colon". I told her, "No. I have no history of any colon problems." The only "history" I had was about 25 years ago when a colon test was done. This test showed everything was clear. (This test had only been performed because I was having problems with my appendix.) Last year during one of my appointments with Dr. Park, she

went through my list of medications, as usual and asked me "What happened with the Celebrex?" I asked her what she meant and she told me that my VA records stated I was allergic to Celebrex. I told her I had never had an allergic reaction to Celebrex and didn't know how the information got in my records. A few months before this, Virginia, who is Dr. Garrigan's nurse, read me the list of my allergies and she said that it was listed that I was allergic to Advil. I told Virginia I had never, ever taken Advil so how could I be allergic to it.

5. The Doctor's at the Hilo PCC are Not Available and Too Frequently "Leaving Early". We Veterans are told that the doctors are available at the 'Hilo clinic, on Monday thru Friday, from 8 am–4 pm. If we come in without an appointment, we are told that we will have to wait for an available opening. I am a member of the DAV Chapter 9, and most members have complaints about coming into the clinic at the above listed times and been told that the doctor had already left for the day. The last time this happened to me was in July, 2005. It was 3 pm and I was told that the doctor had already left for the day. Then the Hilo clinic tells us, "if its an emergency, you can go to the Emergency Room at the Hilo Hospital". Well, the last time I did go to the hospital was because of an emergency was about 2 years ago. I had returned from a CMP exam in Honolulu, and was feeling extremely ill. My wife called the Hilo PCC, around 3 pm and was told the doctor had already left for the day and my wife should take me to the Emergency Room. Well, I was taken to the Emergency Room and I had to pay for my treatment. The VA in Honolulu has refused to reimburse me, claiming that I should have gone to the Hilo PCC instead and are claiming that I did not have "official" permission from the clinic to go to the Emergency Room. There was another earlier time, on a weekend, when I went to the Emergency Room and again the VA has refused to reimburse me, claiming I should have gone to the Hilo PCC. Well, here in Hilo, we don't have the advantage available to Oahu Vets—24 hour Emergency treatment from Tripler.

This next complaints are against the VA in Honolulu.

1. Dental Treatment for 100 percent SC. As I previously stated I received my 100 percent SC Disability this year but it was retroactive to February, 1999. Around 2001, I began having problems with my teeth. I could not afford to have all the work done at this time and was waiting for my 100 percent SC to come through so the VA could take care of my teeth. Almost immediately after receiving my 100 percent, I made my appointments with the dentist. The VA has since refused to complete all the necessary work which the dentist has repeatedly told the VA I need. I have lost a number of teeth. According to the dentist, if the VA had began treatment back in 1999, I would probably still have all my teeth. I cannot chew. On my right side, I have teeth on top, and none on the bottom. On the left side, I have all my teeth on the bottom, but only 1 tooth on top that is being stressed and I could lose this tooth if the VA doesn't act fast.

2. Performing Unnecessary CMP Exams. In my last disability claim, I complained that my hearing was getting worse. When the VA sent me to Honolulu, I thought it was to test my hearing. But this was not the case. I was sent for, what the doctor said was a "preliminary interview & exam to determine if I had any hearing problems". He would than decide if I needed a full hearing test by a specialist. I can still remember his total shock and misbelieve when he found out that I was wearing hearing aids and that the VA had been providing me with hearing aids for years. He asked me 3 times: "Who gave you the hearing aids?" He was furious that the VA was wasting his time. Well, not only was the VA wasting time, but also wasting money on me and my wife's plane fare. (My disabilities make it necessary that I have someone accompany me on flights, especially with all the delays and inconveniences at the airport since 9/11.)

3. Coordinating CMPs and other Exams. There are many other veterans on the Big Island who like me, have a multitude of disabilities. The flight to Honolulu is in itself very difficult and strenuous for us. There have been times when we have had to travel every month or, even twice a month to Tripler for an exam. Why can't the VA schedule us for multiple exams during the same trip? We have been told that veterans from Guam and other localities in the Pacific have their exams scheduled together. The VA would save money on plane fare and we veterans would not suffer as much.

4. The VA has Refused to Pay for Veterans Who Go To the Emergency Room when Hilo PCC Hours is closed. My fellow vets and I on the Big Island are having to pay for our treatments when we go to the Hospital Emergency Room when Hilo PCC is closed. This is why I and many other vets are paying for personal medical insurances (usually both HMSA and Medicare). And, we are repeatedly told by the VA that we are entitled to "full, free medical care from the VA".

The following information is to rebut the statements of November 21, which the VA submitted to you regarding my complaint of October 18, 2005. I know the fol-

lowing is very long and time consuming, but, I hope you will take the time and read this. The Senate Committee may find it enlightening.

I am enclosing a copy of the VA's November 21 letter to your office since my information follows their letter's format.

First, regarding my canceled appointments. In 2004, I canceled only one appointment—my September appointment with Dr. Park, because I would be out of the state. This canceled appointment was one which I was never informed of and learned of only by accident. Please let me explain. On July 22, 2004, I made an appointment to see Dr. Garrigan because I was going to the Mainland and I needed to see her about receiving my medication while I was gone. I was leaving on the first flight out on September 13, 2004 and returning on October 18. I saw Dr. Garrigan so she could order my medication (in 3 month supplies) and get them to me before I left on my trip. Two of my medications could only be ordered monthly, so we determined when I would be receiving them at my home and where I would be in the Mainland, at that time, so my daughter would know where to forward them to me. Dr. Garrigan said she would order the rest of my medication in a 3 month supply. As always on the way out of her office, she handed me a paper which I have to turn in at the front office upon leaving. So, after meeting with Dr. Garrigan, I turned in a paper at the front desk and I made another appointment for September 1, 2004 for a checkup before I left on my trip. At this time, I also told the girl at the desk that I would be out of the state from September 13 through October 18, and to please note it in my records so no appointments would be scheduled while I was gone. (When I returned home, I called the VA in Honolulu. Since I had an ongoing CMP claim. I wanted to make sure that no CMPs would be scheduled while I was gone. Honolulu said I only had a CMP scheduled for August 17.)

At my September 1st appointment, Dr. Garrigan told me that she had personally checked on my prescriptions and I would be receiving my medication before I left for my trip, except for 2 medications which could not be ordered ahead of time. When I left Dr Garrigarin's office, I reported to the front desk, turned in the paper Dr. Garrigan had given me and I told the girl at the desk that I would make my next appointment with Dr. Garrigan when I returned from my trip. At this time, she told me I had an appointment scheduled with Dr. Park for later in the month. I told her that I would be out of the state on the scheduled date and reminded her that I had notified the VA Clinic back in July that I would be out of town so that no appointments would be scheduled. THIS WAS THE ONE AND ONLY APPOINTMENT THAT I CANCELLED IN 2004. I rescheduled my appointment with Dr. Park for November 15, 2004.

I am a member of the DAV, Chapter 9, and my wife and I regularly attend their monthly meeting. At the November 12th meeting I spoke with a fellow Disabled Vet. He mentioned that he also had an ongoing claim and was very upset about some information he had recently found in his VA medical records. One of his complaints was that he received a copy of his VA medical records and in the records were a list of his scheduled VA medical appointments. He claimed to have found numerous cancellations of appointments he never knew he had and several of them were listed that he had personally canceled them. At this time, I had an ongoing claim with the VA and also had an updated copy of my VA medical records at home. When I looked through my records I found that I also had a number of canceled appointment which I knew nothing about and some of them had also supposedly been canceled by me.

There is one appointment cancellation in particular that has caused me the most problem and for which Dr. Garrigan has shown "no compassion". I had been on one particular medication for over 10 years. A couple of years ago, the VA referred me to the VA Pain Specialist, Dr. Park. Because of the severity of my condition Dr. Park suggested that I switch from oxycodone cr to methadone. I was very hesitant about switching mediation because not only had I been on oxycodone a for years. (It had been prescribed to me first in the 1990's by VA doctors.) Dr. Park promised that if the methadone did not work out, there would be no problem with the VA reissuing, me oxycodone a. Also, if she (Dr. Park who came to Hilo once a month) was not available to switch me back, Dr. Garrigan would be able to switch me immediately because she (Dr. Garrigan) had previously been prescribing me the oxycodone a. I was told that in my situation, because the VA had been prescribing oxycodone a to me for years, the fact the oxycodone a had since become a non-formulary drug would have no bearing on me. (This fact was also verified by the VA Administration office in Honolulu.) So, both Dr. Park and the VA concurred that I would be able to get back on oxycodone a without delay or complication. However, I also hesitated because Dr. Park said that methadone was a "last resort" pain medication and all her other patients who were taking methadone to control pain were much older than me. (I was in my 40's).

After a couple of visits with Dr. Park, I did agree to give the methadone a try. Almost immediately, I started getting unusual side effects. In particular, I began feeling extra tired; the hair on my head, chest and legs began thinning; I had great difficulty getting an erection and, my testicles were shrinking. After a couple of months, I spoke to Dr. Park about switching me back to oxycodone a to see if the methadone was the cause of my new conditions. She agreed to change my meds to see if my side effects would change. After Dr. Park switched me back to oxycodone cr, we found that my hair began thickening and I was able to sometime get an erection. Dr. Park said that apparently, the methadone was having an "aging" effect on me. She didn't know if it was the methadone itself or if the methadone was inadvertently triggering the side effects of the numerous, other medications I was taking.

After I had been back on the oxycodone a for a couple of months, Dr. Park, suggested that I consider going back on the methadone until the middle of next year. She explained that she wanted to try and keep my body off the oxycodone cr for a year and then hopefully, put me back on the oxycodone a at a lower dosage. Dr. Park said that if the methadone's side effects got too bad, she would take me off the methadone earlier. So, she again changed my meds.

On November 15, 2004 I saw Dr. Park again. At this time I showed Dr. Park that I had lost all the hair on my chest, the hair on my legs and arms were almost completely gone, the hair on my head had thinned and turned white, and even though I hadn't shaved in 4 days, there was very little hair on my face and, I could no longer get an erection. Dr. Park suggested that since I had come this far with the methadone, I continue with it for another few months and sometime before summer (of 2005), I would be put back again on oxycodone cr, hopefully, at a lower dosage. But then, Dr. Park's entire outlook seemed to change when she began reading the medical records on my examinations from other doctors. Dr. Park seemed very worried when she read Dr. Uramoto's August report that stated how severely disabling my shoulders, arm, and hands had become with rheumatoid arthritis. Dr. Park did comment that she hadn't realized my arthritis was getting so bad. She also said that I may need strong dosages of oxycodone cr after all. We continued to talk. Dr. Park said that she would like to try and continue treating me with methadone for a couple more months. But now (after having read Dr. Uramoto's medical records), she said she would leave it up to me as to whether or not I continue with methadone or go back to oxycodone cr right away. After much discussion between Dr. Park, my wife and myself, I decided to continue with methadone for a couple more months, until I saw Dr. Park again. I felt that my side effects from the methadone couldn't get any worse and I trusted Dr. Park and was hoping that her plan would work. Just before I left Dr. Park, she reiterated that if I decided, at any time, to stop the methadone and go back to oxycodone cr, I could either contact her in Honolulu, or have Dr. Garrigan re-prescribe me the oxycodone cr.

Well, I never got to see Dr. Park again because when I called the Hilo Clinic to make an appointment to see her, I was told that she no longer works for the V.A.—the V.A. did not renew her contract. So, I called Virginia, Dr. Garrigan's nurse and explained the situation to her. She said that all she could do was set up an appointment for me to come in and see Dr. Garrigan. However, Dr. Garrigan was busy and Virginia gave me an appointment for a month and a half later. Well, a month later, Dr. Garrigan herself called me to say that she had to cancel my appointment and I was to call back later and set up another appointment. Because I would have to wait another extra month to see Dr. Garrigan, I decided to see my private doctor, Dr. Festerling who happens to be a former VA doctor who formerly treated me at the Hilo VA Clinic. He is fully aware of all my medical treatments by the VA. He noticed himself that I had "aged" and after examining me, diagnosed that I needed some type of testosterone treatment and that I should go back to oxycodone cr immediately. He wrote prescriptions for oxycodone cr and androgel and also gave me a testosterone shot. He also explained in writing the reasons for these medications. I took all Dr. Festerling's paperwork up to the Hilo PCC clinic and asked if I could wait to see Dr. Garrigan. This was on July 22, 2005 at 3 pm. I was told that the Dr. Garrigan and her nurse, Virginia, had already left for the day. (Note: Veterans are repeatedly told that we can "walk in" to the clinic on Monday–Friday, from 8 am to 4 pm to see the doctor. But if we don't have an appointment, we will have to wait. This was not the first time that I and other veterans have come to the clinic without an appointment and been told that the doctor has left early.) On Monday, I called the clinic and was told that the doctor and nurse were not in. On Tuesday, I was finally able to talk to the nurse, Virginia, and she said that the 2 prescriptions I had dropped off on Friday had "expired" and I would need to go back to Dr. Festerling and have him write another set. I explained to the nurse what was going on. I told her that Dr. Garrigan could at least, just go ahead and switch me from

the methadone back to oxycodone a. The nurse said that the oxycodone was "non-formulary" and special papers needed to be filled out by Dr. Festerling. I explained to the nurse that Dr. Park had said that because the VA had previously prescribed oxycodone, no special papers needed to be filled out. I also told the nurse that if she looked into my records she would see that even Dr. Garrigan herself had prescribed me oxycodone a in the past. I told the nurses that my records would also show that the VA had been giving me oxycodone a since the 1990's. She said she would talk to Dr. Garrigan and get back to me. At this time, I told the nurse that all my medication needed to be reordered. (Every month I have to call the nurse to have my medication ordered.) After talking to the nurse, I called the VA in Honolulu and they confirmed what Dr. Park had told me—since the VA had been prescribing me with oxycodone a for years, no "special papers" needed to be filled to put me back on oxycodone a. The next day, since I hadn't heard from Virginia, I called her and she told me that Dr. Garrigan would not issue me oxycodone a until Dr. Festerling filled out some papers and his papers were approved by the VA in Honolulu. I again tried to explain that both Dr. Park and the VA in Honolulu had said that it was not necessary to request special permission to put me back on oxycodone a, but she would not listen. When I asked if my prescriptions had been processed, I found out that everything but my methadone had been renewed. When I asked what had been substituted for the methadone, she told me "nothing". I was in shock. I said, "Are you telling me that for 10 years the VA has been treating me for pain with either oxycodone a or methadone and now you are stopping me "cold turkey"? Virginia said that yes, Dr. Garrigan was not renewing either medication.

I complained to the VA in Honolulu. I was transferred to several different people. No one could really help me because it was up to Dr. Garrigan. But, several people said that they could not understand why Dr. Garrigan needed to process the medication as a "non-formulary" if I had previously received it from the VA.

And, they couldn't believe that Dr. Garrigan would suddenly stop my pain medication "cold turkey" when I had been on it for years, especially since my recent exams indicated that my conditions has severely worsened. I was advised by the VA in Honolulu, to go back to my private doctor and have him prescribe the oxycodone Cr, fill the prescription myself and then bill the VA. So, this is what I did. I could then submit my receipt to the VA in Honolulu and get reimbursed. (I did submit the receipt to your office and have not yet been reimbursed.)

I was finally able to see Dr. Garrigan a couple of weeks later, on August 3. She said that she knew I had complained to Honolulu about her but claimed that she was in the right because Dr. Festerling had prescribed a non-formulary drug. I told her that first of all, if she had not canceled our appointment, I would not have had to go to Dr. Festerling in the first place. And, second, if she would look in my medical records, she would see that VA doctors, including she herself, had been prescribing me the oxycodone cr. for years. At first Dr. Garrigan denied that she and other VA doctors had prescribed it to me but soon found out from my records that she and other VA doctors had been giving it to me. She then said, "Oh, there is no problem. I can go ahead and write you a prescription for oxycodone right away". So, I asked her, "Doctor, why did you give me such a hard time?" I never got an answer. When she went to take my heart beat, I unbuttoned my shirt and showed her that when I had seen her in January, I had complained to her about a bulge near my navel. I told her that because she had not done anything about it, I had gone to Dr. Festerling and he had referred me to a surgeon who had operated on me. I told her that I would use her as my primary care physician only if she would start treating me. Then when I asked her about the testosterone medication, she seemed surprise that I was having a problem. I told her to look in my medical records and she would see that my problem was well documented. Since Dr. Park was no longer around, it was up to her to do something. And since she hadn't done anything, Dr. Festerling had run tests on me and was treating me with shots and Androgel. Dr. Garrigan said that several treatments were available, however, the VA did not provide Androgel. I told her that I would try anything that was available. She said that she was running out of time and had already spent too much time on me. She said she would check my records and get back to me about my testosterone. When I didn't hear from Dr. Garrigan after a week, I called the VA office and was told that I would have to make another appointment and come in to see her again. The earliest appointment was about 2 month later, on September 29. I had been told several years ago by the VA Patient Advocate that I could bring a tape recorder to my appointments and I have done so a few times. I decided to go to this appointment with a tape recorder. When I saw Dr. Garrigan on September 29, she acted surprise that I was having problems with my testosterone. (Apparently she had totally forgotten about our August 3, 2005 discussion.) Again, my wife and I had to explain everything that was going on. Dr. Garrigan denied

knowing that I was having any problem, even though my problem was repeatedly noted in my VA medical records. I told Dr. Garrigan that I had been waiting to hear from her since the last time I had seen her and she had said she would be treating me. I had not gone back to Dr. Festerling for treatment and had been waiting to hear from her. Dr. Garrigan said she had the past lab records from Dr. Festerling, which showed a low count, but said she wanted a current testosterone count before starting her treatment. I told her that I had just come into the clinic for a blood test 2 days ago. Dr. Garrigan picked up her phone, called the lab and said she wanted to "add a lab" and she "needed it now". The lab results would be available within a day or two and Dr. Garrigan said she would start me on the medication immediately after receiving the lab results and the results would tell her how much medication I needed. Then she told us about the various treatments which were available: weekly or monthly shots, and 2 types of patches. She recommended I use the patches and she explained how to use the patches. She also said that she would need another testosterone count taken about 3 weeks after I go on the patches. Before I left her office she repeated that she would have the testosterone lab results within a day or two and would call us right away so that she could start my treatment. She also said to make an appointment for another lab test in 4 weeks so she could see how the new testosterone patches were working. (Note: I have this entire visit on record. Dr. Garrigan did look directly at the tape recorder which was in my pocket.) So, I made a lab appointment for October 31st. On October 7, 2005, I still had still not heard from Dr. Garrigan regarding the testosterone lab results and the medication she was to be put on. I called the Hilo PCC and was told that neither Dr. Garrigan nor her nurse, Virginia, was in. The woman who answered offered to take a message and I told her to write the following message for Dr. Garrigan: "This is Guy Poulin—when I saw you on September 29, you told me you would get back to me within a day or two and let me know about the medication I would be taking. You wanted me to take new labs within 3 weeks of using this new medication. My lab appointment is on October 31. However, since you have yet to start me on my new medication, you need to reschedule my labs for 3 weeks after you finally start me on this new medication. Please call me and let me know what is going on. My number is . . ." Well, neither Dr. Garrigan called me, nor did she start me on medication for my testosterone. So, regarding my October 31, 2005 lab appointment, I canceled it because the lab test was to see how the new medication was working—THERE WAS NO NEW MEDICATION BECAUSE DR. GARIGAN DID NOT GIVE ME ANY NEW MEDICATION.

Shortly after my October 7 phone call, I complained to the Honorable Daniel Akaka and the Honorable Ed Case.

On November 9th, Dr. Garrigan called me to tell me she was sending me to a colon doctor. She never mentioned about my testosterone. I GUESSED THAT, AS USUAL, SHE HAD FORGOTTEN ABOUT YOU. And, I did not bring it up to her because I had already gone back to Dr. Festerling and had decided that he would regulate any and all of my testosterone treatments. The VA has been inept in treating me for this condition—they had more than a year to do something and after finally promising to treat me, they "forgot" or was it that "they neglected" to treat me.

Another major problem occurred in January of this year. On January 4, 2005. I had my regular appointment to see Dr. Garrigan. I had a bulge on my stomach, near my navel that I had noticed and had planned to have her check it out. She took me in late for my appointment. As soon as I got into her office, she said that she was running late. I began showing her my stomach, when the nurse came and told the doctor there was a phone call. Dr. Garrigan told me to put my shirt back on and wait outside. I went outside. After 15–20 minutes, she called me back into her office. Again, she said she had to rush my appointment because she was running late. She just looked at my stomach, and listened to my heart. She asked about my medication, and I mentioned the problems I was having with my methadone. It seemed that she was not listening to me at all. She hurried me out of the office. As soon as I got home, I made an appointment to see Dr. Festerling about the bulge near my navel. On January 6, 2005, I saw Dr. Festerling who said I had a naval hernia. He referred me to a specialist/surgeon and a couple of weeks later I was operated on.

I am sorry to be so lengthy in my explanation but this is the only way to explain what truly happened. So, briefly, these are the accurate facts which correct the erroneous information which the VA gave to the Honorable Ed Case and the Honorable Daniel Akaka.

1. I only canceled one appointment in 2004. This appointment was made by the Hilo PCC after the office had been told I would be out of state.

2. On November 9, Dr. Garrigan called to tell me she was referring me to a colon specialist. She did not talk to me about anything else. Dr. Garrigan had already admitted on August 3, that she had made a mistake and I could receive the non-formulary medication. In fact she had filled out my prescription while I was still in her office on August 3. And, yes, on August 3, I was mad, because she had given me such a difficult time and had not even had the decency to look in my medical files which would have cleared up the problem immediately. And what about the fact that after years and years of being treated with either oxycodone a or methadone Dr. Garrigan stopped me "Cold Turkey". (The VA pain specialist, Dr. Park had me on both medication for a week as she eased me out of one and into the other) Dr. Garrigan showed a total lack of compassion. And, was it laziness that kept her from checking my medical records?

3. When will I receive attention for my medical conditions. In January 2005 when I went in with a bulging naval, she just shoved me out the door. I had to go elsewhere for my operation. On September 29, 2005, Dr. Garrigan told me she would call me within a day or two and prescribe me a new medication. Well, I gave her over a week, then called the VA clinic to remind her and still I did not hear from her. So again, I am being treated, at my own expense, by a private doctor who I totally respect and who has always shown me great compassion and who knows my entire medical history. Oh, and in the past 2 years, I have only been treated by 2 specialist from the VA, Dr. Park and Dr. Uramoto. However, I have provided the VA with medical records from my Private Primary Care Doctor, Dr. Festerling. And these records include records from several private specialists whom Dr. Festerling had referred me to because of my hernia, (which Dr. Garrigan neglected to treat), and for an auto accident. If the VA wants to take credit for me going to "6 Specialists" then, the VA should pay for the other 4 specialists.

I have one question. Why hasn't the VA answered all the questions that were addressed to them? And, I had submitted a receipt for the Oxycodone CR which I had to pay for because Dr. Garrigan had "forgotten" that she and the VA had previously issued me this medication. I have not yet been reimbursed for the Oxycodone CR.

I am enclosing a brief medication profile which show that I was on "OXYCODONE CR" then put on "METHADONE", and later switched back to "OXYCODONE CR" to check on the side effect, then put back on "METHADONE" and finally returned to "OXYCODONE CR."

In closing, I want to notify the VA that because the VA has for months, neglected to treat me for my low testosterone, on October 24, 2005 I asked my Primary Care Physician, Dr. Buddy Festerling, to be the physician in charge of overseeing all treatments for my testosterone problem. Dr. Festerling immediately took charge and my treatments are ongoing. My testosterone problem is finally being handled and I hope the VA will respect my decision and not interfere with these treatments. I hope that this time you will receive an honest, factual response to my complaints.

I greatly appreciate all your help.

Hon. DANIEL K. AKAKA,
United States Senator,
Honolulu, HI.

Senator Akaka: Thank you for your letter of November 7, 2005, on behalf of W. Guy Poulin, and his dissatisfaction with the medical treatment he received from the Hilo Community Based Outpatient Clinic (CBOC). He expressed concern regarding an excessive number of appointment cancellations. In 2004, there were four appointments that were canceled by the patient and five that were canceled by the clinic due to staff illnesses. Overall, the clinic makes every effort to keep scheduled patient appointments and to notify the patient in a timely fashion if an appointment has to be canceled unexpectedly. The patient is then rescheduled and an appointment notice is mailed to the patient. Recently, the Hilo CBOG has implemented a new scheduling process called "open access" to allow more flexibility in the scheduling of appointments and to assure that patients are seen in a timely manner.

Dr. JoAnn Garrigan, who is W. Poulin's primary care provider at the Hilo CBOC, called him on November 9, 2005, to discuss the issues that were presented in his letter. She related that the patient was angry about a medication that he did not receive from the VA. This medication could not be ordered for him because any prescription request was not served from his outside provider, and the patient did not present for his requited laboratory appointment to determine if this particular medication was needed.

Dr. Garrigan also stated that Mr. Poulin has received attention to his medical conditions and that no complaints were ever ignored. Over the past 2 years, he was referred to six different specialists for a total of over 20 visits. The Hilo CBOC staff also noted that W. Poulin usually came to the clinic with his wife and did not recall

them ever leaving the clinic feeling angry or upset. W. Poulin has indicated that he would like to continue his medical care with Dr. Garrigan as his primary care provider.

PREPARED STATEMENT OF MASTER SERGEANT KEITH T. RIBBENTROP (RET.), USAF, MBA

I am pleased that you are here today with expressed concern for Hawaii Veterans. It is very timely because this week it is with a great deal of pride and joy that we welcome home members of the 29th Infantry Brigade returning from deployment in Iraq. With their return, we welcome 1000 new combat soldiers to rank and file of Hawaii State veterans, more than three hundred of these soldiers are residents of Hawaii County their smooth reintegration to their civilian life is of utmost concern to us all.

Hawaii County is the residence of approximately 14 percent of the State Veterans population; this population receives about 20 percent of the Disability Compensation paid to service connected disabled veterans in the State. The numbers demonstrate that while the number of service-connected veterans in the county is relatively small their health care needs are more challenging. A further, affordable and welcoming living condition has facilitated significant growth in the number of older veterans in the county. Between the 1990 and the 2000 census, Hawaii County experienced a 105 percent growth in the age group 55–64; for many of these veterans the Veterans Health Administration (VHA) is the sole source for health care. As these veterans age, their health care needs will increase, creating additional demand on an already heavily taxed healthcare system. The rapidly growing number of eligible and new beneficiaries to the health care system challenges capacities and creates potentially unsafe conditions in care delivery. The Veterans Benefits Administration (VBA) has limited presence in Hawaii County providing Veteran Service Representative (VSR) Outreach visits twice each month, once in Hilo and once in Kailua-Kona. Because of time and travel considerations, it can take up to 2 months to file a claim with a VSR. I have worked with veterans to resolve issues with the VA. Veterans experience a full spectrum of frustrations from receiving wrong medication in the mail, to fear of a bad mark on their credit report because the VA has not paid a bill in a timely manner and the service provider has come to the veteran for payment. The most difficult are those that report life-threatening and disabling conditions that the VA will not provide care for because the condition is not service connected. Further, veterans speak of health care providers seemingly more engaged with the tasks related to documenting what they are doing versus actually providing care while in the same breath give testament to caring people working in a health care system that is taxed well beyond its capacity. Likewise, in talking with the VHA healthcare providers have similar frustrations with regard to facility size, with inadequate space, or no space for the providers to do their work. Depending on the complexity, veterans may receive care through any number of medical service providers throughout the state. Two veterans I have met, both from Hawaii County, have had surgical procedures performed on them at Tripler Army Medical Center under the contractual sponsorship of VA. For these veterans the care did not result in a positive outcome and they were further damaged because of the surgeries. The veterans accepted the provided care trusting that the VA would provide certain rights and remedies. These cases have been addressed by the Board of Veterans Appeals and the claims have been denied citing that compensation benefits are not available under 38 U.S.C. A. 1151 for disability caused by hospital care, medical or surgical treatment, or examination furnished at a non-VA government facility through which the VA contracts. The Court has held that "where the law and not the evidence is positive, the claim should be denied or the appeal to the VBA terminated because of absence of legal merit or the lack of entitlement under the law." Sabonis v. Brown, 6 Vet. App. 426,430 (1994). These veterans from the County of Hawaii did not receive treatment equal to that received by their mainland comrades by in large because we do not have a VA Hospital to deliver that level of care.

In their claims preparation there were no statements of Informed Consent completed with the nurses or physicians of either VA or the Department of the Army; nor can the veterans recall any verbal counseling regarding choices. Informed consent is the process by which fully informed patients can participate in choices about their health care. It originates from the legal and ethical right patients have to direct what happens to their body and form and the ethical duty of the health care provider to involve patients in their health care. Without informed consent, these veterans were not aware of the nature of the decision, reasonable alternatives, relevant risks, benefits, rights, or remedies. They trusted that the Department of Vet-

erans Affairs was acting in their best interest when it referred them to Tripler Army Medical Center for surgery. In the State of Hawaii, the VA can only provide a small number of medical procedures; the majority is conducted under contractual agreement. Compensation benefits are not available under 38 U.S.C.A. 1151 for disability caused by hospital care, medical or surgical treatment, or examination furnished at a non-VA government facility through which the VA contracts, therefore, the veterans in Hawaii do not receive care or benefit equal to their mainland comrades.

General George Washington established the Purple Heart decoration in 1782. The Purple Heart is unique in that the individual is not recommended, rather entitled to it upon meeting specified criteria; the first of which is for wounds suffered in action against an enemy of the United States. During the Vietnam Era, the Department of Defense established a program called Project 100,000. Individuals selected for participation were allowed to enlist the military even though they did not meet minimum enlistment criteria. Two Hawaii County veterans who at the time of their conscription had less than a ninth grade education and enlistment qualification scores that cause serious doubt with regard to their ability to reason. They carry a diagnosis of Post Traumatic Stress Disorder and have serious physical problems because of the wounds and trauma they received in combat; both received discharges under Other Than Honorable Conditions. After their separation they re-entered society and functioned as best they could, given their individual mental and physical limitations. They have come to the VA seeking medical assistance for their war related injuries, and denied that care because of the character of their discharge. Their character of discharge prevents the VA from delivering medical care for the traumas of combat injuries. It seems morally and ethically corrupt that the county would draft a man, send him into combat, then confer upon him the Purple Heart for his actions and then turn its back on him for medical conditions resulting form his combat experience. In determination of their requests for health care that the VHA and the VBA become a bureaucratic dynamo in their resolve to say no; applying what appears to be a bar from compensation claims to those of health care. Compassion would seem to be in order, and if it is not, then it would seem that legislation to allow these decorated American Veterans access to care for their war related injuries would be.

Island life is different from life on the mainland; from the culture, we live in to the way we get from point A to Point B. A veteran on the mainland can, if necessary, hitchhike to a VA regional facility; on an Island, hitchhiking will get you to the other side of the highway from where you started. Compounding problems in Hawaii County is the lack of mass transportation. Disabled American Veteran vans supply some relief, but it is necessary to understand that our island has the nickname "Big Island" for a reason. It is possible for a veteran to miss a ride and have to remain overnight in Hilo or Kona. Certain VA care and services require veteran travel to Honolulu. Travel to the VA Regional Center always involves air travel. When a veteran is eligible, the VA provides reasonable travel accommodations and consideration in scheduling with understanding that the veteran has to move through his schedule quickly to enable them to get home that night.

Employment of technology particularly video conferencing has provided great relief for many veterans receiving services from the VHA. The technology could be employed equally well within the VBA. For example, a veteran who appeals compensation decision from the VBA and requests a Regional Hearing or a Video Hearing before the Board of Veterans Appeals must always travel to a Regional Office. From neighbor Islands in Hawaii, that travel is always by air; some mainland veterans must travel tremendous distances. If a veteran is unable to travel alone and needs accompanied travel—his costs double. The De Novo Review process has helped many veterans who when presented with the associated costs, would simply drop their appeals and therefore their claims. The Technology is available within the VA—however, it does not appear to be fully employed. Another example, changing a Direct Deposit: through the Defense Accounting and Finance "MyPay" system takes roughly 4 minutes. An equivalent change with the VA can take up to fifteen minutes after you have made contact with a service representative, it can take several hours of telephone busy signals to get to that point, not to mention the time zone change considerations. Similar examples of lost time and frustration could be made for Life Insurance, Debt Management, Educational Benefits, Home loans and CHAMPVA. It would seem that broader employment of technology and allowing the veteran to perform simple tasks via the internet would both reduce the frustration on the veteran and the overhead costs to the government.

In closing, I wish to thank the Veterans Affairs Committee for this opportunity to testify on behalf of all of the veterans in the State of Hawaii. I hope you will seriously take into consideration all the concerns brought to your attention.

PREPARED STATEMENT BY GEORGE TAMLIN

I am 100 percent disabled veteran, was referred to your Office by Barbara Morgan, the Patient Advocate at Spark M. Matsunaga Center. I have Osteoarthritis and I have on many occasions over the past 9 months requested a consultation with a specialist for the condition. I have made these requests through Dr. Rivera at the Community Based Outpatient Clinic in Hilo and a visiting VA Rheumatologist, Dr. Inmura (I have probably misspelled the name). I initially requested the consultation because I was losing strength and loosing my ability to grip and hold things. It has progressed to a point now that the loss is now affecting my personal hygiene. I continue to loose strength—and I still have no referral or relief in sight. I request your help in getting me the proper medical attention I need.

PREPARED STATEMENT OF CAROLLE BRULEE WILSON

VA HEALTH CARE AND BENEFITS CONCERNS

What's right?

• Appointments are being outsourced here locally so as to receive travel stress on the veteran instead of traveling to Honolulu for a 20 minute appointment, consuming your Whole day with travel time

• Medications arrive in a likely manner through the mail system

What's wrong?

• The Hilo vet center is not authorized to allow any veterans groups to utilize their conference rooms for meetings. According to supervisory personnel, "it's in writing. Why? I hope the planned new vet center doesn't operate that way. In addition, I hope the planning of the new vet center would include to have All of the veterans offices in one building.

• The procedure for obtaining license plates at the county's DMV office should be streamlined. An id card and a DAV membership card mean nothing as far as obtaining license plates. You are instead asked to produce your dd214.

Again as they do not keep records. Perhaps a standard Letter from VA Honolulu retained on file would help.

• When applying for property tax exemption, the Hilo property tax office requires you to mail the forms to VA Benefits in Honolulu to obtain the signature required. Why Isn't someone here authorized to sign this document?

• Hilo Women's Veterans Organization to hold a homeless veterans Standown. This effort failed. Honolulu has had several successful ones. I would like to have onsite direction and support from the person/s who conducted their event so that we may hold One here as well. We need to do something for our homeless veterans.

• Veterans here since many don't drive, should be given a bus pass to ride at no charge.

PREPARED STATEMENT OF WENDALL E.K. KEKUMU

Aloha Honorable Daniel K Akaka, U.S. Senator, Hawaii and Members of the U.S. Senate Veterans Affairs Committee:

I wish to take this time to introduce myself, my name is Wendall E.K. Kekumu, I served in the Army Airborne that I consider apart and quite different from the regular Army units. I also served with the U.S. Army Reserve unit at Fort De Russey and the U.S. Army National Guard.

I was service connected for malaria and rated at 0 percent and chronic back injury rated at 10 percent. Service at the VA was adequate but difficult in the beginning since you could only receive service for those conditions connected to military service. Today my rating is at 100 percent permanent and total.

With that rating you'd think that the service provided by the VA would include all medical conditions regarding my health, well the truth is "NO" I still receive treatment only for service connected conditions.

While employed at the Pearl Harbor Naval Shipyard from 1978 to 1986 I left my job after a long term injury and left through the Naval Dispensary clinic for depression in 1984 and received treatment from the Honolulu Vet Center and psychiatric service from the VA. In 1986 I was terminated from my employment because I

didn't report to work as ordered. After negotiating for 1 year I was allowed to retire with medical conditions from the Shipyard. I did not receive any service from this organization until 1989.

I maintain this medical plan for use by the dependents and continued to utilize the services at the VA. And within the last 5 years the VA began to solicit reimbursement from this medical plan for my treatment of diabetes that I was "told" was service connected by the CBOC nurses and physicians.

I had to apply for service connection of diabetes with the VA and was service connected for this condition. It seem unfair to me that a veteran who is rated at 100 percent and does not have medical insurance for his dependents are treated without cost yet for me that have insurance that I have never used for myself are penalized for having insurance.

The VA enrollment for veterans seemed like a good plan if you didn't have any type of health insurance. I misinterpreted the word enrollment as being covered for all medical services provided by the VA where in "fact" it still only applies to the service connected conditions.

It is therefore my disappointment that this new enactment of policy at the VA only takes care of those veterans without health insurance and those veterans providing health insurance coverage for his dependents are unfairly penalized.

In October 2003, I kept an appointment at CBOC in Hilo for the continued monitoring of blood sugar levels for diabetes and submitted an application to renew my permanent disability plagued to the LPN.

I did not have a cardiac distress or difficulty with breathing when I was ask to walk down a hallway and back was the reason given that they would not sign off on the application for a Hawaii County Disability Plagued. I had to ask my doctor which I did.

I applied for and was issued a Disability Plagued in Tacoma, Washington, Eastport Idaho, Honolulu Hawaii and Hawaii County. Not until my plagued expired in 2003 could I ever imagine that CBOC's LPN, Medical Doctor and whoever is in charge of this responsibility, interpretation of the application would not allow the renewal of my application for a disable plagued.

It seem over reaching one's authority in this situation and unless this is corrected, I continue to suffer from there decision for not renewing my disability plagued.

Aloha P mehana.

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