

**Substance Abuse Task Force**  
**October 24, 2008**  
**10:00-3:00**  
**Park Research Center**

**Meeting Summary**

**Attendees:**

*Task Force/Steering Committee:* Sherry Bradsher, Sonya Brown, Anthony Burnett, Chris Collins, Tony Foriest, Robert Gwyther, Paula Harrington, Carol Hoffman, Verla Insko, Larry Johnson, Kevin McDonald, Sara McEwen, Paul Nagy, Marguerite Peebles, Janice Petersen, Martin Pharr, William Purcell, Jane Schairer, Starleen Scott Robbins, DeDe Severino, Flo Stein, Michael Watson

*Interested Persons:* Barbara Alvarez-Martin, Trish Blackmon, Tad Clodfelter, Sheila Davies, Michael Eisen, Denise Harb, Jessica Herrmann, Greg Hughes, Dylan Jones, Nidu Menon, Thomas Szigethy,

*Staff:* Thalia Fuller, Mark Holmes, David Jones, Jesse Lichstein, Pam Silberman, Berkeley Yorkery

**WELCOME AND INTRODUCTION**

*Representative Verla Insko, North Carolina General Assembly*

**THE MINIMUM LEGAL DRINKING AGE**

*Michael Eisen, MA, LPC, State Coordinator for Preventing Underage Drinking Initiatives, Division of MHDDSAS, NC Department of Health and Human Services*

While research exists in support of both higher and lower drinking ages, the majority of the evidence points towards an inverse relationship between the minimum legal drinking age (MLDA) and both alcohol consumption and traffic crashes. Experiments in several states point towards this inverse relationship; Michigan, Massachusetts, and Wisconsin all experienced an increase in traffic accidents and fatalities when the MLDA was lowered, and a decrease in traffic accidents and fatalities when the MLDA was increased back to 21. The decreases were experienced in two specific groups: 16-20 year olds and 21-24 year olds. Coinciding with states adopting a MLDA of 21 are lower rates of drinking in both high school and college age students, decreases in under-age and binge drinking, and a decrease in both alcohol and non-alcohol related fatalities, including traffic accidents.

In the United States research shows that important parts of the brain continue to develop until around age 25, and that alcohol use before this time can permanently damage the brain. In addition, youth who wait until they are 21 to consume alcohol for the first time are less likely to develop a dependence on it.

In efforts to reduce drinking on college campuses, access and demand of alcohol, alcohol policy, and community norms need to be examined. The same is true for efforts wishing to reduce

under-age and high-risk drinking. Comprehensive community mobilization is also an important factor in efforts to reduce youth drinking.

*Discussion:*

Discussion focused on delaying onset of drinking, the influence of the liquor industry on MLDA, and the success of the Chapel Hill/Carrboro Coalition. Social costs of raising or lowering MLDA and creation of a “brand” for not drinking were also discussed.

**WHY SIGN? THE AMETHYST INITIATIVE AT DUKE**

*Thomas Szigethy, Associate Dean, Director of the Alcohol and Substance Abuse Prevention Center, Duke University*

College campuses are playing catch-up when it comes to informing students about alcohol related problems other than drunk driving and its consequences, due to a lack of alcohol education in high school and lower schools. The problems being addressed at Duke University include alcohol poisoning, assaults, high risk drinking, drinking to get drunk, alcohol as an excuse for behavior, drinking behind closed doors, damaged relationships, and damaged property. Many students view drinking as a social lubricant, however a good deal of these students are drinking to get drunk, which is not additive to the social interaction. In addition, most college age students have a skewed view of their relationship to alcohol and do not know how to interact with or confront a friend or peer that has an alcohol problem.

By signing the Amethyst Initiative Duke University hopes to openly contribute to the discussion of college age drinking. It is hoped that the discussion will produce a more in depth look at the issue by examining all the risks associated with drinking, the influence of American culture on the perception of alcohol and drinking, the messages being sent to school age children, and the literature on college age drinking.

Possible policy changes to address college age drinking include controlling the supply, encouraging moderation of behavior, curtailing advertising, using the smoking prevention model, utilizing a curriculum that has an impact on lower grades, and teaching beyond abstinence.

*Discussion:*

Discussion focused on the American culture of alcohol, the need to talk about the problems associated with drinking and not simply the age issue, how to make choosing not to drink or drinking in moderation worth it to college students.

**VAMC DURHAM: SUBSTANCE ABUSE OVERVIEW**

*Greg Hughes, Chief of Social Work Services, Durham VA Medical Center*

Approximately 50,000 veterans are served through the Durham, Raleigh, Greenville, and Morehead City Veterans Affairs clinics. It is expected that this number will rise as more units return from deployment and as deployments continue. Two distinct populations are being served: veterans 55 and older who served in Vietnam through World War II, and veterans 18 to 30+ years old who served in Operation Enduring Freedom (OEF, Afghanistan) and Operation Iraqi Freedom (OIF). Non-OEF/OIF veterans seeking substance abuse treatment tend to have

undergone previous treatments, have a lack of primary supports, have multiple mental health diagnoses, and have a high rate of homelessness and divorce. OEF/OIF veterans are usually young, just out of the military, never married, living with their parents, trying to go to school or work, and are seeking care for substance abuse for the first time. Of OEF/OIF veterans, almost 25% of both active duty and reserve veterans acknowledge a significant alcohol problem or alcohol abuse. Between 2005 and 2006 the number of alcohol related incidents, including DUIs, drunk and disorderly conduct, self-injury, and suicidal behavior, in the military have increased. In addition, rates of post traumatic stress disorder (PTSD) and substance abuse increase with repeated deployment, and most service men and women are being re-deployed 3 to 5 times.

Most of the OEF/OIF veterans receiving substance abuse treatment had problematic use before military service, have increased use since return because they use alcohol and drugs as a coping mechanism, experience isolation to hide use, and want to quit or reduce use. However it is usually general readjustment problems that bring them into treatment, not the recognition that they have an alcohol or drug problem.

The VA uses a primary care Substance Abuse Treatment model. With this model there is an assessment and diagnosis and a brief intervention for the patient. Patients are then referred to specialty care where they receive care management and treatment, and later follow-up care. North Carolina also offers step-down care for veterans leaving detoxification programs.

**“COMING HOME”: THE NC FOCUS ON RETURNING COMBAT VETERANS AND THEIR FAMILIES**  
*Flo Stein, Chief, Community Policy Management, Division of MHDDSAS, NC Department of Health and Human Services*

North Carolina Focus on Returning Combat Veterans and Their Families is a partnership between federal, state, and community providers and programs to aid returning veterans and their families with substance abuse and mental health information, services, and readjustment assistance.

North Carolina is the fourth largest military state in the nation, with 7 military bases, over 100,000 active duty members, and over 11,000 National Guard and Reserve members. With the move away from base living to “home base” troops, where families stay at home while a family member is deployed, there is a need for new types of supports for families and veterans. This new demand for support services has caused the military to turn to a community capacity building model of delivery.

North Carolina has participated in both national and state-wide collaboration efforts to discuss and address substance abuse and mental health issues of returning veterans, including The Governor’s Summit on Returning Combat Veterans and Their Families. This Summit envisioned a “referral network of informational, supportive, clinical, and administrative services that will comprise a system through which citizens of North Carolina will have access to post-deployment readjustment assistance for veterans and their families.” Since the Summit, much progress has been made. A statewide initiative to increase awareness, knowledge, and skills of community practitioners in relation to the medical and behavioral health needs of veterans and their families has been implemented, North Carolina’s “Care-Line” went 24/7/365, and the

Technical Assistance Center for Homeless Veterans Providers was established. A statewide registry of trained Licensed Clinical Addiction Specialists is being developed, workgroups are developing specialized training and educational programs, and the North Carolina General Assembly approved the recommendation to add a target population for veterans and their families with substance use disorders, mental health problems, and traumatic brain injuries.

North Carolina's team from the National Behavioral Health Conference and Policy Academy on Returning Veterans and Their Families has created several tools: Operation Kids on Guard to help children deal with deployment of their parents, Living in the New Normal for children of military families, and Sesame Street, a series of DVDs dealing with fears, wounds, and bereavement for military children.

**DOD, VETERANS AFFAIRS, STATE AND COMMUNITY PARTNERSHIP IN SERVICE TO OEF/OIF SERVICE MEMBERS, VETERANS, AND THEIR FAMILIES**

*Harold Kudler, MD, Coordinator, Mental Health Service Line for the Mid-Atlantic Veterans Integrated Service Network*

*Associate Director, VA Mental Illness Research, Education, and Clinical Center on Deployment Mental Health*

*Associate Clinical Professor, Department of Psychiatry and Behavioral Sciences, Duke University*

The Department of Veterans Affairs (VA) currently serves 5.5 million veterans, approximately 1 out of every 5, and is the largest provider of mental health and substance abuse services in the world. The VA provides services through medical centers, ambulatory and community outpatient clinics, nursing homes, residential rehabilitation treatment programs, Veterans Centers, comprehensive home-care programs, Department of Defense (DoD) and VA polytrauma centers, My HealthVet, and veterans integrated service networks.

As of May 2008, 40% of OEF/OIF veterans had already sought care, 42.5% of whom sought care for mental health issues. The top diagnoses were for PTSD, nondependent use of drugs, and depression, but diagnoses indicate a tripling of alcohol and drug dependence. The Post Deployment Health Assessment (PDHA) and the Post Deployment Health Reassessment (PDHRA) indicate that approximately 20.3% active duty and 42.4% reserve service men and women required mental health or substance abuse treatment post-deployment from Iraq. However, 60% of veterans have not sought care through the VA system.

Most veterans will not develop a mental illness, but all veterans and their families face readjustment issues. Use of a public health model, requiring integration of services, would move the focus to these readjustment issues to help veterans and families retain a healthy balance in their lives. The program would need to increase access to services, reduce stigma, and proactively engage prospective users instead of waiting for them to seek care. To enhance access and quality, the DoD and the VA are partnering with states, including North Carolina, and communities to strengthen interagency communication and coordination.

The North Carolina Governor's Summit on Returning Veterans and their Families concluded with the following goals: improving exchange of information about respective agencies;

identifying strategic partners; articulating an integrated continuum of care; emphasizing the principles of resilience, prevention and recovery; and optimizing access to care, information, and support. Future goals include enhancing outreach, increasing appropriate referrals, reducing stigma, promoting healthy outcomes, increasing consumer and provider satisfaction, developing and strengthening partnerships, and transforming the post-deployment health system.

*Discussion:*

Discussion focused on shifting state programs down to the community level, improvement of collaborations, homelessness among veterans, and length of time National Guard and reservists can receive services from the VA.

**LARGE GROUP DISCUSSION & IDEAS FOR POTENTIAL RECOMMENDATIONS**

*The VA System*

- Training of Department of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) and Local Management Entities (LME) providers to orient them with the VA system.
- Provide trainings for pediatricians, family physicians, internal medicine, and psychiatrists.
- Develop local community and VA coalitions to provide supports for military and National Guard families.
- Development of a Medicaid traumatic brain injury waiver

*College Drinking*

- Support development of campus and community coalitions to reduce alcohol related consequences.
- Not lowering the minimum legal drinking age below 21
- Program model for universities to try and implement over time
- 0-0-1-3 low consumption model for college campuses
- Media literacy campaign