

# Posttraumatic Stress Disorder and Comorbid Substance Misuse in the UK Armed Forces: a Protective or Facilitative Environment?

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The association between PTSD and alcohol misuse is well-established, but there is still a paucity of data to support a link between PTSD and drug misuse. The causal relationship between combat related PTSD and substance misuse is thought to be a combination of shared risk factors and self-medication of symptoms. The author uses her experience of 14 years service in the Army to explore whether the military environment is protective and facilitative for substance misuse.

Compulsory drugs testing in the UK Armed Forces creates a protective environment for drug misuse, with lower rates than the civilian population. However, service personnel discharged for illicit drug use could be at greater risk of dependence due to the sudden loss of earnings, accommodation and support networks.

Screening for substance misuse post-deployment is not currently undertaken in the UK, but a trial is currently underway by KCMHR. The US have found limitations in screening for substance misuse in the decompression period as individuals have not had access to alcohol or drugs for the duration of the deployment. There may also be limitations to a screening programme in service personnel reluctant to admit problems to a uniform-clad military medical practitioner.

**Posttraumatic stress disorder and comorbid substance misuse in the UK Armed Forces: a protective or facilitative environment?**  
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**Background**  
 Comorbid substance misuse in individuals with posttraumatic stress disorder (PTSD) is widely reported<sup>1</sup>. Military patients are an interesting sub-group who have all experienced similar trauma, and have similar socio-demographic characteristics. Unlike the civilian population, service personnel are subject to certain restrictions which may serve as preventative factors for substance misuse. However, the immediate explosion of anyone falling to adhere to these regulations, suggests that some individuals are left potentially unsupported when at their most vulnerable.  
 This essay explores co-occurrence of PTSD and comorbid substance misuse in the UK Armed Forces. The author uses her experience of 14 years service in the Regular Army to explore whether the military environment is protective or facilitative for substance misuse.

**Combat related PTSD and substance misuse**  
**Comorbid association from common aetiology**  
 Service personnel who experience PTSD symptoms are more likely to have low educational attainment, low pre-enlistment socioeconomic status and high pre-enlistment vulnerability<sup>2</sup>. These are at risk factors for both PTSD and alcohol abuse. This clustering of demographics may be due to the fact if an individual with these demographics are more likely to join the infantry and therefore be at increased risk of engagement in traumatic combat, compared to an individual deployed in a non-combat role.  
**Alcohol as self-medication in PTSD**  
 The self-medication model has been around since the 1970s, and describes individuals misusing substances to self-medicate and experience distressing or unpleasant symptoms, both physical and mental. Research into the self-medication model is as yet inconclusive. A snapshot of examined alcohol misuse in the context of PTSD symptom clusters (intrusive, effortful avoidance, numbing and hyperarousal) expecting to corroborate the self-medication theory that alcohol is used to dampen hyperarousal symptoms in PTSD. Despite finding a trend towards an association between hyperarousal symptoms and alcohol misuse this was not significant, and they recommend further research in this area.

**The consequences of punitive compulsory drugs testing**  
**Drug use protective factors**  
 All service personnel are subject to regular, unannounced, compulsory drugs testing (CDT), with the punishment for a positive test result being discharge from service. Drugs that may be tested for in CDT include all those classified as a 'Class C' controlled drug under section 2 of Misuse of Drugs Act 1971. Between 2001-2009, the overall positive test rate in the British Army was only 7.0 per 1000, 20 times lower than self-reported use by civilian 16-24 year olds in the British Crime Survey or 5000 CF employees. The most common substance found in CDT is cocaine (16% of individuals testing positive), followed by cannabis (30%), ecstasy (18%)<sup>3</sup> (Linking to Army 'CDT' data)<sup>4</sup>.  
**Discharge from the military environment**  
 The peak age for enlisting into service is 18 years old<sup>5</sup>. For many young service personnel away from home for the first time, the military becomes a substitute family to them, with free meals, accommodation, discipline and excellent welfare support. When a serviceman is discharged following a failed CDT they are normally out of the unit within two to four weeks. In the end of this short period they are effectively isolated and homeless and forced to move away from their existing support network. For an individual who has a history of drug misuse this is the least conducive environment to rehabilitation and can facilitate a decline into dependence and transition to other drugs.  
 A recruitment package is provided by the military designed to identify vulnerable individuals, however the National Audit Office found that there were 'inconsistencies in the quality of support offered'<sup>6</sup> and the recruitment process was described as 'haste and poorly monitored'<sup>7</sup> by the House of Commons public accounts committee. Evidence suggests that less than 1% of compulsory discharges are referred for support<sup>8</sup>.  
 \*Note: some individuals test positive for more than one substance.

**The Armed Forces' complex relationship with alcohol**  
 A study conducted in the Royal Navy in 2008 found that 92% scored positively on AUDIT-C test and ~60% scored high enough to be put in the high risk group for AUDIT<sup>9</sup>. Internal papers have been published giving commanders clear guidance on alcohol consumption however it still remains a large part of military life and social events are very often based around five or cheap alcohol.  
 During an operational deployment service personnel are either prohibited from drinking alcohol completely or restricted to two or three alcoholic drinks (before or after) because of - this period of enforced abstinence, deployment has been shown to increase the risk of binge drinking in the following months<sup>10</sup>.  
 In order to mitigate this, and other mental health problems, the MOD introduced a good operational stress management package. All deployed service personnel are required to attend decompression period (usually in Cyprus for 24-36 hours) which includes briefings on mental health issues, alcohol misuse and leisure activities. A soldier may receive a briefing on alcohol misuse, then 2 hours later purchase 5 cans of beer (6 'rounds') and relieve the stresses of the deployment with alcohol in the evening. Are they considering self-medication?  
 The US Armed Forces undertake mental health screening in their post-operational stress management phase. The UK does not currently screen service personnel during its decompression period. As alcohol and drug consumption is severely restricted during deployment (to better manage accessibility), it is unclear how screening for alcohol misuse disorders can be undertaken at the decompression point. There may also be limitations to screening due to reluctance of servicemen to admit to a problem for fear of punishment.

**Key Points**  
 • The causal relationship between combat related PTSD and substance misuse is thought to be a combination of shared risk factors and self-medication of symptoms.  
 • Compulsory drugs testing in the military creates a protective environment for drug use, with lower rates than the civilian population exist. However, service personnel discharged for illicit drug use are particularly vulnerable.  
 • Misuse of alcohol consumption is high amongst UK Armed Forces personnel than the civilian population, despite measures over the last decade to reduce this.  
 • Screening for substance misuse post-deployment is not currently undertaken in the UK, but a trial is currently underway by KCMHR.  
 • There are limitations to post-deployment substance misuse screening due to restrictions on consumption in theatre. There may also be limitations due to the hierarchical structure of the military and a reluctance to admit to problems.