DRUGS AND THE SOLDIER

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Editor's Note

The author was appointed last year as consultant in charge of the Alcohol Treatment Unit in the Psychiatric Division of the Queen Elizabeth Military Hospital. As a civilian who for five years held a Home Office licence to prescribe for drug addicts during her previous appointments in the National Health Service, she is able to draw on both her own and colleagues' extensive recent experience in the field of drug abuse.

Soldiers are recruited from and continue to mingle off duty with the rest of society in which drug abuse is by no means uncommon. Yet, apart from alcohol abuse, which is a national problem, and smoking, drug abuse in the Army is rare. It will remain so only if constant vigilance is exercised.

Drugs and the Soldier was the title of a useful article in this Journal eight years ago¹. Dr Blunden attempts here to give the subject a 1980s perspective. She is also willing to be consulted directly by members of the Army Medical Services.

Introduction

Recently the Customs and Excise Department have reported huge hauls of heroin, cannabis and cocaine, while both the lay and medical press have been occupied with articles on various facets of alcohol abuse². Clearly the problem of abuse of substances affecting cortical functioning continues to flourish, and to show its usual changes in fashion. That such abuse will continue seems highly likely in view of the lengthy past history, dating back beyond recorded historical times. That they affect soldiers is indicated by the fact that in the past two months I have seen soldiers who were abusing heroin intravenously, cannabis, amphetamines, LSD, barbiturates, analgesics, anti-Parkinsonian agents, benzodiazepines and glue. The majority of my time is however occupied with the consequences of the most popular drug abuse, both of the general public and of the soldier, alcohol.

Types of drug abuse

Alcohol abuse

The misuse of alcohol is undoubtedly a major problem, affecting all ages and all ranks. Both the non-dependant and dependant abuser suffers multiple consequences, and the resultant reduction in mental and physical efficiency have far-ranging effects on the functioning of the individual. When compounded with the preoccupation with legal, social and financial complications of alcohol abuse, the individual's work output may drop severely, affecting the efficiency of his unit. Many of these individuals are highly (and expensively) trained, yet these deteriorations in function are often allowed to continue until a major

medical or disciplinary crisis makes avoidance of their recognition impossible. Doubtless this pattern is seen because of the ambivalence towards alcohol both in the service, and in society in general, and the reluctance to apply the term 'alcoholic' to an individual whose drinking has, in some way, become damaging. There can be no doubt, however, that an individual whose drinking has resulted in problems (be they medical, at work, legal, marital, financial or any other kind), has a problem with drink. This individual may well, in the long term, and surprisingly often in the medium term, be grateful for recognition of his problem and offers of help.

Cannabis

Cannabis taking (usually smoking) is common in Britain and usually unrelated to any psychiatric or psychological problem. It is readily available, and easily grown in this country. Arguments continue as to whether its use produces long term psychiatric effects, Western experience being too short and information from traditional users being contaminated. Acute excessive use produces a toxic delirium, but it is usually used to produce a heightening of sensory imagery and a sense of relaxed well-being. The worried, bored or frustrated soldier may use it as an escape and tranquilliser; the disaffected, discontented, as a form of rebellion.

Opiates

Of the opiates heroin is by far the most popular with the abuser. The supply of sterile BP ampoules has dwindled and huge quantities are imported illegally, adulterated or even substituted with almost any other substance (from chalk to strychnine). Since the user has no idea of the nature of what he is actually taking, and since it is almost always taken by unsterile IV injection, unpredictable and sometimes dangerous effects can occur. This type of drug abuse is rare, and would be difficult to conceal in most circumstances of service life. Physical dependence occurs less readily and less often than once assumed. The abuse of methadone linctus developed when this was used in withdrawal programmes, and resembles the (probably commoner) abuse of cough mixtures containing codeine and its derivatives usually with sedatives such as antihistamines. These latter proprietary mixtures are available over the counter.

Barbiturates

The legal supply of these has diminished greatly with the reduction in prescribing of barbiturate hypnotics, though they are more readily obtained on private prescriptions. Barbiturate abuse orally resembles alcohol abuse. Abusers addicted to IV abuse (rather than to a specific drug) frequently inject non-injectable preparations, with serious medical and surgical consequences.

Amphetamines

These have also ceased to be readily available with the voluntary ban on prescribing them which exists in most National Health Service practices and in the Army. They and their analogues are also more easily obtained privately,

purportedly for weight reduction. They are apparently readily obtained illegally in many areas. They may be used as self-medication in depression, but more often form part of unselective drug abuse. Physical dependence does not occur, but psychotic illness may be precipitated in vulnerable individuals.

Prescribed drugs

The abuse of prescribed drugs is almost certainly much commoner than is supposed. The benzodiazepines, either prescribed as sedatives or hypnotics, are by far the commonest drugs involved. Large supplies may easily be obtained legally by individuals having access to more than one medical practitioner, and considerable traffic between relatives and friends also occurs. They are also readily available illegally. Alcohol abusers also abuse sedative drugs, the current favourite being diazepam (Valium) which is known as "eating booze". Virtually every drug having a psycho-active effect may be abused, including antidepressants, anti-psychotics and antidiarrhoea agents. Drugs used in psychiatric practice obtain, from time to time, an apparently undeserved reputation for producing 'kicks', judging from the reluctance with which those for whom they are genuinely prescribed take them!

Other hallucinogens

Many plants contain hallucinogens, and ill-educated investigations into their potential can produce puzzling and dangerous, even lethal, effects. One hallucinogen LSD, is a simple compound, easily manufactured and equally easily obtained, though unreliably so. If genuinely consumed it can produce a dangerous psychotic state, though individual susceptibility is clearly very variable. Other synthetic hallucinogens are available such as STP and PCP (Angel dust), but less widely at present.

Cocaine

This is evidently returning to fashion, but to what extent, and what style of use will be associated with it, remains to be seen. A Californian company is marketing a substitute (intended for sniffing) supposedly safe, but containing adrenalin derivatives, called 'Toot'. This will no doubt appear elsewhere, though one hopes not legally.

Other substances

The ingenuity of people in the search for substances which will alter consciousness means that almost every substance, however unlikely, has been investigated. Volatile agents have long been abused — including anaesthetic agents, amyl nitrite, petrol and trichlorethylene. Industrial solvents have proliferated and are readily abused, necessitating closed systems in engineering plants. The commonest current solvent source is the abuse of modern glues. This abuse often starts in school age children, the glue being sniffed from inside a plastic bag to facilitate volatilisation. The obvious dangers of asphyxiation and fire add to the medical effects of hydrocarbon inhalation. There is an association with later development of alcohol or drug abuse³.

Identification of drug abusers

The essence of making any diagnosis is to think of it. Most servicemen are mentally and physically fit. Recurrent reporting sick with vague symptoms, inadequately explained absences or injuries, uncharacteristic behaviour or poor work performance should all raise suspicions. These suspicions should arise early, and can be supplemented not only from the individual himself, but by examination of his past medical history, annual reports and conduct sheets. Serious suspicions necessitate a full medical, psychiatric and family history, including the nature of the individual's employment and even his spare time activities. Physical examination is also revealing. The homesick young recruit may help himself to a handful of his mother's diazepam while on leave, or to the antidepressants his older sister was prescribed after her marriage broke down. The formerly efficient LCPL may have been brought up in a home where drunkenness and violence is the norm, and his 'normal' drinking, (ie drinking to get drunk) may have reached the level of 15 to 20 pints of beer a day with five or six doubles 'to make sure' and 'a couple of cans' first thing in the morning. The bored and under-employed driver, with nothing to do in the afternoon, may consume huge volumes of beer resulting in recurrent renal pain, increasing obesity and decreasing activity. The promising PTE who performed well during the Northern Ireland tour may, on return to the depot, seek release from frustration at not doing what he was trained for by obtaining amphetamines from 'punks' at his local. Everyone has ample access to alcohol, but the mess barman, the 'good Mess member' and even the doctor may all be damaging themselves by their drinking. The reggae enthusiast will have easy access to cannabis; and the isolated, discontented, adolescent can obtain heroin, LSD etc, if he is disaffected and rebellious enough, and particularly if he has access to the ports and large conurbations.

Psychiatric predisposition to drug abuse

It is often assumed that abuse of drugs is the result of pre-existing abnormality. This is extremely rare. There is no particular type of personality underlying drug abuse, including that of alcohol, and the development of such abuse is usually based on a complex interaction between the individual's personality characteristics and his socio-cultural setting. Hence it is obvious that if the abuse ceases, the individual can return to making a useful contribution, even an enhanced one, if during the change in his behaviour he has also acquired insight and maturity. Of the circumstances leading to drug/alcohol abuse, boredom, under-employment, lack of job satisfaction and lack of group cohesion are at least as important as more obviously stressful situations. A minority of abusers are misfits with no motivation for change, and have no contribution to make to the Service, and administrative discharge is indicated in these cases. It may require expert advice to identify the even smaller minority in whom abuse is related to pre-existing psychological or psychiatric disorders, though a full personal history and clinical assessment will help to identify possible cases where the abuse is an attempt to self-medication⁴. Assessment of such individuals for

specific diagnosis and treatment is a matter for the experts, and a fairly large proportion of such cases will respond to treatment.

Withdrawal syndromes

By far the most commonest withdrawal syndrome is delirium tremens, which occurs 3 to 4 days after withdrawal of alcohol from a physically dependent subject. It occasionally occurs in such individuals who are unable to consume their habitual quantities because of intercurrent (usually alcohol-related) illness or military exercises. It is dangerous and can be life-threatening, even if it occurs without concurrent acute physical illness. If arising in the severely injured or seriously ill patient, say with acute pancreatitis or after major surgery, or in the coronary care unit, early, immediate and effective treatment is imperative. The withdrawal syndrome in barbiturate dependence is similar, equally dangerous, and arises sooner after withdrawal, and grand mal fits are even more common than in alcohol withdrawal.

Opiate withdrawal syndrome is less common than assumed, since physical dependence has been (in contrast to alcohol) overestimated. The true syndrome includes copious lachrymation, rhinorrhoea, vomiting and diarrhoea. In 15 years of clinical psychiatry I have seen this syndrome on one occasion only.

There is continuing dispute as to whether benzodiazepines cause a withdrawal syndrome⁵. Abrupt withdrawal of other sedatives and hypnotics, and tricyclic antidepressants, may carry the risk of grand mal seizure.

It should be remembered that drug abusers seeking drugs overestimate their intake, whilst those seeking to avoid the consequences of their abuse minimise it. The majority of drugs abused have no withdrawal syndrome, the important practical exceptions being alcohol and barbiturates, and withdrawal should not be diagnosed in the absence of unequivocal physical signs.

Emergencies relating to drug abuse

It has already been pointed out that by far the commonest of these are those arising from alcohol abuse. Alcohol abusers are liable to a greatly enhanced risk of a variety of medical emergencies, and any such emergencies may be accompanied by the risk of development of delirium tremens, with possible fatal effect. Referral of a seriously ill patient known to abuse alcohol should always be accompanied by this information, so that steps can be taken to prevent the development of withdrawal syndrome. The withdrawal syndrome, except in its mildest form, always requires hospital admission. Toxic confusional states may arise from the abuse of many other drugs and also require hospital admission, as do psychotic reactions persisting for more than a few hours. Intravenous abusers of drugs, apart from overdose, may give rise to a variety of medical emergencies unrelated to the actual drug involved. The commonest psychiatric emergency is probably suicidal behaviour or threats whilst the individual is intoxicated, usually with alcohol. Alcohol abusers are at a very much greater risk of suicide than the general population and such behaviour requires supervision at least until the individual sobers up.

Referral of alcohol and drug abusers

It follows that this is dependent on the abuser being identified as such by the referring doctor. A proportion of abusers present themselves for treatment, though this does not necessarily indicate positive motivation. Identification of abusers depends on the ability of the referring doctor to add up the clues, and confirm his suspicions by enlarging his knowledge of the individual's history. Open and frank discussion is best from the start, and doctors should not underestimate the therapeutic value of this alone. In spite of the efforts of specialist departments, there is evidence that in the long-term their contribution has little advantage over a few individual discussions with the patient's own doctor⁶. The doctor must make up his own mind as to the urgency of the referral, patients often demanding instant treatment for other reasons than are immediately apparent. The receiving psychiatrist is not likely to be impressed by an emergency referral whose F Med 4 contains clear evidence of alcohol abuse for 10 to 15 years! Hostility is the common, if not the usual, response to suggestion of referral. This should not deter the referring doctor, and in any case initial motivation is no guide whatsoever to eventual outcome. The only advice possible to the undoubted alcohol abuser is total abstinence for a least a year, in spite of the incredulity with which this advice will, at first, be received. 'Cutting down' merely results in rapid re-escalation to former or even greater levels of intake.

Future studies

Readers interested in the subject of 'alcoholism in the Army' are referred to an article of the same title, which covers the demographic survey of those admitted for treatment to the Royal Victoria Hospital, Netley over a period up to 1977⁷. It is hoped to repeat this survey for more recent years, and to gain some idea of the outcome of inpatient treatment on the Alcoholic Treatment Unit at Queen Elizabeth Military Hospital, Woolwich. I also hope to survey the incidence of drug usage currently, and particularly in relation to pre-enlistment use, to discover whether any predictions of service behaviour can be correlated with it.

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