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From the editor



Dr Dominique Florin

Alcohol and the military

The main article in this issue of *Alcoholis* relates to the extremely topical problem of alcohol abuse among current and former soldiers, and its relationship with PTSD. The medical director of the charity Combat Stress, Dr Walter Busuttill, gives us an idea of the scale of the problem. Alcohol abuse in this group is often a result of underlying PTSD, so treating the alcohol problem without regard to the underlying cause is generally unsuccessful. Routine mental health services may not be familiar with the likely complicating factors in veterans, who may present many years after leaving the military, so organisations such as Combat Stress provide a unique and much-needed service. In the accompanying anonymous letter by the daughter of a former soldier, these issues are brought vividly to light, particularly the terrible effects not just on individual servicemen but also on their families. This topic will be explored further at the seminar on the subject of 'alcohol and the military' on the afternoon of our AGM on 16 November, at BMA House. We hope many readers will be able to attend.

Alcohol in the undergraduate curriculum

The education of medical students is one of the core concerns of the MCA. In this issue, Christine Goodair describes the 'Substance misuse in the undergraduate curriculum' project in medical schools in England, founded by Professor Hamid Ghodse at St George's, University of London.

Several of our regional advisers (RAs) have been involved in this project. Based in medical schools all over the UK, our RAs play an active role in promoting medical students' understanding of alcohol and health. We are hoping in future to set up a web-based forum to share the experiences of RAs in different medical schools.

'Responsibility deal' on alcohol

You may have seen the press coverage of the decision by six national medical bodies not to sign up to the public health 'responsibility deal' on alcohol. Among the organisations is the Royal College of Physicians, with which the MCA is affiliated. This was supported by Sir Ian Gilmore on behalf of the Alcohol Health Alliance, of which we are a member. The view was taken on the grounds that effective legislation to reduce excessive alcohol consumption was being neglected in favour of ineffective voluntary agreements with the alcohol industry. The decision got extensive media attention.

In the journals

Two recent journal articles may be of interest to members. In the November/December issue of our own journal, *Alcohol and Alcoholism*, Rachel Seabrook of the Institute of Alcohol Studies suggests a revision of the standard method used to calculate the official UK measure of alcohol affordability.¹ This is important because it results in a measure which correlates more closely with alcohol consumption over the past decade. In *The Lancet*, a widely-reported article by Sheron *et al* described the enormous extent of alcohol-related morbidity and mortality nationally and internationally.² The authors report that, in developed countries, alcohol-attributable morbidity is second only to that caused by tobacco. Liver disease is the prime cause of alcohol-related deaths and an important measure of the damage caused to society by alcohol.

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Military psychiatry – clinical services for service personnel and veterans

Dr Walter Busuttill MBChB MPhil MRCPG FRCPsych RAF (retd), consultant psychiatrist and medical director, Combat Stress

Military psychiatric care is organised into multidisciplinary departments of community mental health (DCMH) situated all over the UK and overseas. Access to high-standard mental health care is rapid, and hospital services are contracted out to an NHS consortium. In combat zones, multidisciplinary psychiatric field teams are deployed.

Clinical audits indicate that approximately 5,000 new referrals present to military psychiatric care every year, and that common clinical presentations include alcohol misuse, depression, anxiety and adjustment disorders, with low rates of post-traumatic stress disorder (PTSD) (4%) in the military population.¹ Overall suicide rates in servicemen and women are similar to civilian rates, and are even lower in some age groups, with one exception: suicide rates among ex-servicemen under the age of 24 are two to three times higher than in the civilian population. Reasons for this are unclear, with causes suggested including: existing vulnerability before entering service, trouble re-adjusting to civilian life, and exposure to more adverse experiences.²

Veterans and substance abuse

Combat exposure is associated with higher levels of alcohol misuse, especially in younger servicemen. In one study, heavy drinkers (>30 units per week) were compared with light drinkers (<20 units per week). Heavy drinking was associated with current military service and being unmarried, separated or divorced. Heavy drinking was more common in younger personnel who had been deployed to Bosnia. Those who drank heavily were also more likely to smoke, and heavy drinking was associated with poorer subjective physical and mental health.³

A more recent study conducted in personnel deployed in the wars in Iraq and Afghanistan demonstrated worrying rates of alcohol misuse, as high as 13%.

This study also demonstrated increased levels of PTSD in British personnel deployed to Iraq or Afghanistan, of between 4% in war theatre personnel overall (this percentage was no greater than comparable non-deployed personnel), 5% for the Territorial Army (with compared non-deployed levels of PTSD at 1%), and 6.9% for front-line combat troops.⁴ These figures are low compared with those in US and Australian studies, which demonstrate levels of up to 20% in combat veterans in some studies.⁴

Combat exposure is associated with higher levels of alcohol misuse, especially in younger servicemen.

Studies identify the range of comorbidity of PTSD and alcohol disorders to be 41–85%. This far exceeds the 19–29% prevalence of alcohol abuse or dependence in the general male population.⁵

Alcohol disorders and PTSD are less likely in US combat populations who also served in Afghanistan and Iraq, compared with the UK armed forces. These discrepancies may be due to cultural differences: UK populations are likely to drink alcohol more heavily than US populations, and people in the UK are less likely to verbalise mental health problems compared with the US population.⁴ Other reasons for this are thought to be due to differences in the methodology of studies, as well as a lower dose–response effect following the

implementation of ‘harmony guidelines’, which in comparison limit the duration and frequency of deployments for the British soldier. Psychiatric problems increase if these guidelines are breached, with particular difficulties observed in those whose tours are unexpectedly extended.⁶

Many ex-servicemen report that they were unable to present for help with mental health problems during their military service. Reasons given include fear of losing their career, a macho culture, and social stigma. Many report drinking alcohol to excess in order to cope with mental health symptoms.

A study conducted in UK veteran populations claiming war pensions showed that ex-servicemen were twice as likely to develop delayed-onset PTSD as civilians, and that 36% of veterans who suffer from delayed-onset PTSD developed it within the first year of leaving the services, suggesting that the loss of military support structures and adjustment to civilian life increase vulnerability. Many who developed delayed-onset PTSD reported major depressive disorder and alcohol abuse prior to onset of the condition.⁷

Some 25,000 servicemen and women leave the military every year. In Britain, a veteran is defined as someone who has served in the armed forces for at least one day; there are approximately 5.5 million veterans and 7.5 million family dependents.

Since 1948, the NHS has been responsible for looking after veterans’ health. Until recently, no specialist NHS services for veterans have existed. Within the last 18 months, the Ministry of Defence (MOD) and NHS, aided by the national charity for veterans’ mental health – Combat Stress – set up six pilot sites across the country aimed at signposting veterans into mainstream mental health care. Other new NHS

initiatives include the 'Improving access into psychological therapies' (IAPT) programme. The MOD offers mental health assessment services to veterans at St Thomas' Hospital in London, and for reservists at Chilwell in Nottingham. Newer initiatives include setting up a national helpline for veterans and their families, better pre-release screening for mental health issues prior to exiting the military, follow-up health surveillance initiatives for those who have left the military, online treatments and support, and the funding of thirty posts within the NHS to champion veterans' mental health, as well as the setting up of NHS veterans' armed forces forums to enhance access into mental health care.

Combat Stress

The third-sector charity Combat Stress originated in 1919. Combat Stress is a strategic partner working with the Department of Health (DH) and the MOD, and has been cooperating with government departments on the initiatives mentioned above. Combat Stress is the leading veterans' charity which delivers mental health care; some 100,000 veterans and their families have been helped over the years.

Combat Stress offers treatment within an environment that is sensitive to the military culture, offering a supportive therapeutic milieu that encourages peer support. Many staff are ex-military; in particular the regional welfare officers who are the first point of contact are all ex-military officers who share a common background and culture with veteran patients. Combat Stress offers community mental health treatment and welfare, telephone help and advice, as well as specialist evidence-based residential group and individual multidisciplinary treatments, carers' groups and rehabilitation. Treatment aims to plug the veteran back into his or her local NHS services. Joint working with other ex-service charities and work re-training schemes is the norm.

Combat Stress is funded by the NHS in Scotland. In other parts of Britain, it is funded partly through the War Pensions Agency, with 60% of its overall funds being charitable. In the past six years, there has been a 72% increase in

requests for its help by veterans, their families and other referrers, with a steady increase in Iraq and Afghanistan veterans, currently presenting at a combined rate of approximately 160 new cases per year. Around one half of all referrals convert to clinical cases every year. Patients are offered a residential or – where services exist – a community outreach multidisciplinary team mental health assessment.

Background, diagnosis and treatment

Large new patient clinical (n=604) and psychometric audits (n=704)⁸ demonstrate that 92% of new clinical cases will have been exposed to multiple military-related psychological traumas, with 75% qualifying for a primary diagnosis of PTSD. Comorbid presentations are as high, with 62% commonly suffering from depression



Charity Registration:
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Many of our heroes can't help reliving the horrors of war.

Please help CombatStress.org.uk to help them.

- ▲ Combat Stress is a military charity specialising in the care of veterans' mental health.

and alcohol misuse. The clinical picture is further complicated, as 52% of the veterans have other underlying issues, including exposure to childhood trauma, neglect and poor care giving.

There is typically a delay of an average of 14 years after military discharge before a veteran presents to the charity. This delayed presentation usually means that chronic complex clinical conditions are the norm, with loss of social and occupational function, self-imposed isolation, poor relationships, and marital, family and economic difficulties. However, some 80% of new clinical cases will have tried to access help through the NHS, but for some reason this help has either been inadequate, or not been delivered if the individual has failed to engage.

Treating mental health problems in veterans is complicated, because of pre-service difficulties, including exposure to childhood trauma, which are often the reasons behind joining the military in the first place. Military life itself can contribute through exposure to bullying, alcohol, psychological trauma or family problems resulting from cyclical deployment-related separations. Veterans are more likely to experience earlier onset of physical disorders, including orthopaedic problems with chronic pain and deafness, as a result of occupational exposure. Veterans with chronic PTSD can suffer a higher-than-expected incidence of other physical disorders including cardiac problems and diabetes, with large US veteran studies demonstrating that such physical illnesses, and premature death, develop ten years earlier compared with veterans without PTSD.⁹

Leaving the service and adjusting to civilian life can be a problem, and there are similar issues when it comes to seeking help, including shame, stigma, guilt, and a macho image. These factors can prevent the veteran seeking help and admitting they have a problem. Indeed, most referrals to Combat Stress come from family members – usually the partner or wife.

Many with alcohol disorders cannot be treated psychologically until

they have undergone detoxification. Cooperation between Combat Stress and statutory NHS services is required for psychological interventions to be delivered seamlessly, in order to reduce chances of relapse back into alcohol misuse. The ideal treatment involves detoxification followed by intensive psychoeducation about PTSD and its interaction with alcohol and other substance misuse, before further trauma-focused therapy is delivered.⁸

It has been noted that many who have sought help from local services find that mental health professionals without experience of managing psychological trauma associated with the military service tend to focus on substance misuse, social problems, and anxiety and depression, while failing to tackle the root cause, seldom recognising the problem as combat-related PTSD.¹⁰

Veterans' mental health needs are currently being publicised because of media coverage of the wars and the plight of the physically wounded. The mental health scars are expected to become more evident over time.

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The 2011 MCA Annual General Meeting and afternoon symposium on 'alcohol and the military' will take place on Friday 16 November at BMA House

To reserve your place, please contact Sapphire Ellison:

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In this letter, the daughter of a former soldier describes the effect of her father's PTSD and alcoholism on her family.

Hello,

For as long as I can remember I have been dealing with mental health. Not my mental health but that of my Dad. You see, before I was even thought of my Dad went to war. He was 17 years old when he went to the Falklands War with 2nd Battalion Scots Guards. He experienced sights, sounds, smells that most of us could never imagine. We always knew that there was something wrong with Dad; why did Mum cry so much; why did we always have to pick Dad up from the pub when he was supposed to be at work; why did dad forget again to pick me up from school? It didn't make sense to me until I was 15, and then something clicked. One day Dad was in the garage, almost unconscious, babbling about someone who he's served with. I knew something was seriously wrong. Mum was trying to sort Dad out whilst I was calling local hospitals Mental Health Units, sobbing, BEGGING them to see my Dad. Each time I was told, your GP needs to refer your Dad, maybe you should seek some help for yourself. I didn't need help for me, I needed help for my Dad. Our GP was ignorant, probably not through his fault but through the general lack of knowledge about PTSD induced by war. Several times we were told Dad couldn't get help because he was an alcoholic and needed to recognise that before anyone would help him. Dad used alcohol to treat a problem that no one else would/could treat. Alcoholic treatment programs did no good because alcohol wasn't his problem, the nightmares, flashbacks, anxiety were his problem, alcohol use was merely a symptom.

Dad became involved with Combat Stress late 2005, he never really committed properly to his engagements with them, outwardly it seemed he would go because we begged him to. Along came an opportunity to heal the wounds. He visited the Falkland Islands with Combat Stress, part of a larger pilgrimage to mark the 25th anniversary of the war. We always knew this was a gamble, it would make or break his recovery, turns out it was to do both for my Dad.

One night in 2007, shortly after the pilgrimage Dad had gone missing, not at work, not at any of our friends houses and not at any of his usual drinking holes (you see my Dad is a creature of habit, he was always in one of a few). My cousin stumbled across my Dad, in full camouflage in a bush near his house, not far from our house. Dad was armed, highly agitated, and he was mumbling about someone who he was waiting for. He had little recognition of my cousin, thankfully was persuaded to come out of the bush and go home with my cousin and Mum was able to talk him down. He thought he was outside a particular persons house and was waiting for them to come out, he had every intention of causing them harm because they had let him down 24 years ago. He was volatile, a ticking bomb. Who knows what would have happened if it hadn't been my cousin who found him!!

So here comes the break... In November 2007 Dad told my Mum that he was going to kill himself or her, he literally begged my mum to get him some help. Mum called the police (who were brilliant beyond words) and he was taken to our local A&E, this sadly was where the compassion and brilliance stopped. The psychiatrist told my Mum that Dad should be seen in the community and that she should take him home and he needed to stay off the alcohol. Dad hadn't had a drop to drink, he was perfectly sober and crying out for help, still

being told there was nothing anyone could do to help, they were all so wrong. They were literally sending him home to kill himself. Thank god for my Mum's stubbornness. She insisted that Dad be taken as an inpatient to the mental health unit, after hours of arguing and stamping her feet he was placed under the care of mental health act and was admitted to a local mental health unit. He was there with people with anorexia, schizophrenia and other mental health illnesses. Do you think any of them could relate to what my Dad was going through? The staff were so overworked, under resourced and had a severe lack of knowledge about my Dads illness. My Dad was having to tell them that he was only prescribed ONE sedative not TWO as the nurses repeatedly tried to give him. One psychiatrist told him that he had no idea how to treat him and that there was nothing he could do for him. He was there for two months.

And the make... Combat Stress to the rescue again!!! The Consultant Psychiatrist at Combat Stress gave advice to the mental health unit that Dad was in and when able made a place available to Dad at one of their short stay treatment centres. Dad left the MHU to go to Combat Stress. Three years on, four short stays with Combat Stress, a change in GP, and some understanding of what Dad is going through and Dad is almost a different man.

Combat Stress is a charity that looks after ex servicemen and specialises in managing symptoms of and treating PTSD or 'Combat Stress' as well as other mental health illnesses that have been induced by the experiences in war. Not only have they made and continually adapted a treatment plan for Dad but they have referred him to other agencies to ensure that he has maximum support socially, financially and clinically.

Dad has put on weight, eats proper meals, sleeps throughout the night without terrifying nightmares, can stand in a crowd without anxiety, doesn't drink alcohol, is interested in the world around him and above all recognises that he is not alone and he should not be ashamed.

Recently a friend stated ignorantly that PTSD was an excuse used for all manner of bad behaviours and he questioned the existence of PTSD. I couldn't believe it, my well educated, intelligent, medically trained friend expressed this view which kicked off a heated debate about the reality of PTSD. It really hit me that people just do not get it. People still think that mental health isn't a reality, that people don't have to deal with these issues day in day out, these people are doctors, nurses, policy makers, budget allocators, war pension tribunals, employers.

Every day is a challenge, a flashback, an unusual smell, footage on the news but each and every day my Dad grows stronger, he laughs, he cries, he lives and he does it all knowing consciously that whatever the next day brings Combat Stress are right behind him, ready if he falls, supportive if he doesn't.

I am writing to you to not only tell you some of the story of the incredible man who is my Dad but also to ask you to please help raise the profile of mental health in ex-servicemen and specifically of Combat Stress who work tirelessly to improve the mental health and quality of life of each and every person who they come into contact with.

Only through smashing through the taboo around mental health will we be able to improve services available to ex servicemen, the NHS is doing a great job rehabilitating soldiers with physical wounds but are far far behind on offering the same to those with psychological wounds. Please help us up the ante.

Thank you for reading

Substance misuse in the undergraduate curriculum

Christine Goodair, national coordinator, St George's, University of London

The use and misuse of alcohol, drugs and tobacco is one of the greatest health challenges today. It has an impact on patients, their families, and the community in general.

Those who misuse substances will inevitably be seen by doctors, who therefore have a vital role to play in recognising substance misuse and in assessing and managing the problems associated with this. Substance misuse as a subject in the medical curriculum does not have a high profile, and if our future doctors are to succeed in dealing with the problem of substance misuse, they require a better understanding of the problem and the interventions which are available.

In 2005, a national project was set up with funding from the Department of Health (DH). It is led by Professor Hamid Ghodse, director of the International Centre for Drug Policy (ICDP). There is a national Steering Committee, chaired by Professor Peter Kopelman, Principal of St George's, University of London, with representatives from the Council of Heads of Medical Schools, the DH, the Home Office, the General Medical Council, the British Medical Association and its Medical Student Committee, and the World Health Organization. The project is being run by the ICDP with the aim of improving the education of doctors in substance misuse issues, and to develop a

consensus approach to substance misuse training in medical schools.

The outcome of the first phase of the project was the production of a UK corporate guidance document, *Substance misuse in the undergraduate medical curriculum*,¹ with a toolkit that covers core aims and learning outcomes for undergraduate curricula, and good practice on delivery. The guidance sets three aims for undergraduate medical student education in substance misuse, covering learning, teaching and societal aspects:

- 1 Students should be able to recognise, assess and understand the management of substance misuse and associated health and social problems, and contribute to the prevention of addiction.
- 2 Students should be aware of the effects of substance misuse on their own behaviour and health, and on their professional practice and conduct.
- 3 Students' education and training should challenge the stigma and discrimination that are often experienced by people with addiction problems.

The DH has funded the implementation and development phase of the project in the English medical schools with the following aims:

- to complete and validate a toolkit and teaching and learning resources in order to advance the implementation programme
- to enhance and equip medical schools to further develop substance misuse learning in their curricula
- to work with medical schools to pilot and evaluate the implementation of the substance misuse curriculum.

The project employs a national curriculum coordinator/manager to oversee the management of the implementation phase, and to work with the participating medical schools. At a local level, each school has an academic champion and a curriculum coordinator, with responsibility for mapping and reviewing substance misuse teaching and implementation into the school curriculum, and the assessment of learning objectives.

A forum of national experts and academic champions – including the MCA – has been a cornerstone of providing technical, knowledge and skills in the programme.

If you would like to know more about this project, please email the author at cgoodair@sgul.ac.uk.

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The Medical Council on Alcohol is a small national charity committed to improving the medical understanding of alcohol-related problems.



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