

XII. Substance Abuse in the Deployment Environment

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Comprehensive screening for substance abuse requires a three-part analysis. Health care providers should focus on behavior prior to deployment, during actual operations, and post deployment. Each situation deserves special, but brief and focused, screening.

For the vast majority of individuals the notice of impending deployment unleashes a myriad of cognitive and behavioral reactions. These reactions are generally mild and transient as the individuals' healthy coping mechanisms respond to the news. In a minority of cases the fear and uncertainty of the looming deployment precipitates a maladaptive response. Among this group, a fairly significant number will turn to substance abuse as a means of quelling the troubled pre-deployment emotions. In fact, current numbers estimate that roughly one-third of the American population meets criteria for problem drinking. Naturally, that figure would be higher among individuals manifesting varying degrees of behavioral difficulties.

A reasonable pre-deployment substance abuse screening strategy might begin with the general, but openly stated recognition, that a pending deployment normally elicits a wide range of emotions. An innocuous screening interview might begin with a question such as: "Individuals run the gamut from being excited to being petrified when notified of their deployment - what best characterizes your reaction?" Another question or two, based on the answer to the first question, could address the individual's coping style. For example, if an individual relates that the notice of deployment created a sense of anxiety and panic the health care provider might ask, "How are you handling your anxiety?" or "What makes you feel less stressed?" or "What plans are you making now that you have the notice of deployment?". Finally, a comment such as, "Some people find that drinking a bit more alcohol, smoking a few more cigarettes, or pouring some extra java helps relieve the stress – have you noticed this in yourself?" If this question prompts the individual to disclose tendencies in the direction of increased substance use, the health care provider should then conduct a more formalized screen using the quantity-frequency questions followed, as appropriate, by the CAGE questions.

The quantity-frequency questions require three simple steps:

- ① First ask, "On average, how many days a week do you drink alcohol?"
- ② Then ask, "On a typical day when you drink, how many drinks do you have?"
- ③ Multiply the days of drinking a week times the number of drinks.

For example, an individual might report drinking a six-pack of beer Friday night and both weekend days. Using the above formula (3 days a week X 6 drinks per typical day) results in a score of 18. Any score exceeding 14 for men or 7 for women suggests an at-risk behavior. The next question in the quantity-frequency screen asks, "What is the maximum number of drinks you had on any given day since learning of your deployment?" A score exceeding 4 for men or 3 for women again suggests a potential problem with alcohol (Dawson, 2000).

Individuals identified by the quantity-frequency screen should next be asked the CAGE questions. CAGE is an acronym for the following questions:

- C** — Have you ever felt that you should **CUT** down on your drinking?
- A** — Have people **ANNOYED** you by criticizing your drinking?
- G** — Have you ever felt bad or **GUILTY** about your drinking?
- E** — Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (i.e., as an **EYE-OPENER**)?

Individuals endorsing either 3 or 4 of the CAGE questions over the past year are most likely alcohol dependent. If the individual endorses 1 or 2 of the CAGE questions they may have current alcohol abuse. Combining the introductory screening comments with the quantity-frequency and CAGE questions can reliably predict 70-80% of individuals with alcohol abuse or dependence (Friedman et al., 2001).

The same screening tool can be adapted for illicit drug use. For example, the initial questions about the person's response to notification of deployment might uncover the use of marijuana. The health care provider can then ask quantity-frequency questions followed by the adapted CAGE. Unfortunately, there are no predetermined cut-off scores for all the potential drugs of abuse, requiring the substitution of clinical judgment.

The screening tools described so far will help guide the care provider's thinking in determining the best intervention for the individual awaiting deployment. Persons with a CAGE score of 3 or 4 will require a more in-depth clinical evaluation focusing on alcohol or drug related disability. If further evaluation confirms the presence of alcohol or illicit drug dependence, the care provider should determine whether imminent deployment is in the best interest of the individual and the military mission. The care provider might recommend a diversion for treatment before deployment.

Individuals with a CAGE score of 1 or 2 will also require additional assessment. The focus here once again is on impairment but the range of possible interventions may not interfere with deployment. The care provider might determine for example that the spike in alcohol or drug consumption is temporary and will likely abate with a strong suggestion that abstinence or reduction is essential. Part of the decision-making may center on the availability of alcohol or drugs in the theater of operations.

Typically forgotten in the abuse assessment are common legal products such as tobacco and caffeine. An increase in either prior to deployment may represent a soft warning signal that portends later problems. A substantial increase in the use of nicotine in the days leading up to deployment may be followed by a corresponding reduction once the individual arrives in the theater of operations. Many factors may promote the reduction, such as lack of availability or less free time, but the outcome will be the same. Nicotine withdrawal, most likely unrecognized, will produce irritability, dysphoria, and sleep disturbances.

Once the individual arrives in the theater of operations the stress of combat will be amplified by any preexisting, yet undetected, substance abuse problems. Two broad scenarios are possible. If the theater has easy access to drugs or alcohol then the pattern of abuse may continue or accelerate. If drug or alcohol acquisition is difficult, then the individual may experience symptoms of withdrawal. Clinicians in Iraq report that alcohol is easily accessible. Early on in the deployment, many soldiers were allowed to go to marketplaces in the cities where "black market"

diazepam was cheap and readily available. Abuse of this drug decreased after trips to the marketplaces were discontinued for safety/security reasons.

The previously discussed substance abuse screening questions have just as much applicability in the combat zone as in the pre-deployment phase. The simplicity, and accuracy of the screening questions, is ideally suited to the triage environment of combat. Given the statistical frequency of substance abuse in the American population the care provider must strongly suspect any cognitive behavioral symptoms arising in combat as the product of either ongoing use or withdrawal. Many of the signs and symptoms of alcohol withdrawal are easily misinterpreted. An individual presenting with autonomic hyperactivity, sleep difficulties, agitation, and anxiety may be suffering from withdrawal and not a combat related acute stress disorder. Appropriate detection could prevent an unnecessary evacuation and lead instead to a brief in-theater detoxification.

Once again, care providers in the combat zone should screen for the common legal substances such as tobacco and caffeine. Prompt recognition of tobacco withdrawal symptoms could lead to a prescription for some form of nicotine replacement therapy. New products that help quit smoking such as bupropion and mecamylamine hold promise too. A subsequent period of observation may help distinguish the interaction between withdrawal affects and local stressors.

Any provider considering evacuating an individual from the theater of operations for a substance abuse disorder should carefully consider advising the individual about the likely treatment options and the impact on a military career. Hopefully, individuals evacuated from a combat zone for a substance abuse disorder will have been counseled regarding the value of treatment and the ultimate expectation that recovery will lead to future, productive military service, including possible redeployment to the combat zone. Care providers at the secondary or tertiary level facility can then assess the individual and recommend appropriate outpatient or inpatient treatment.

The clinician must consider the role of the military command regarding alcohol and drug related problems. A standing order prohibiting the use of any alcohol or illegal drugs exists in deployed environments. As a result, the military commander usually becomes involved when a soldier is identified in an alcohol or drug related incident. Commanders vary in their biases as how to handle these situations, but in general try to balance their concerns for the individual soldier's medical/treatment needs with the need for unit discipline. Commanders often look for direction in balancing these legitimate concerns and usually appreciate input from mental health providers in making such decisions. At times, an inappropriately high level of tolerance of substance use or abuse occurs in some units. This may be more likely in National Guard or Reserve units. Some mental health clinicians in Iraq report that alcohol use in some units was prevalent to the degree that officers, NCOs and junior enlisted drink together. Though rare, such circumstances create significant challenges for proper unit functioning and for the effectiveness of mental health interventions.

Aside from screening for the common legal and illicit substances, the care provider in all phases of deployment should consider the role of herbal supplements, over the counter medications, and steroids. Another commonly neglected, but easily screened issue, involves the potential abuse of prescription medications.

Screening is also important in the post-deployment environment, where some individuals may resume previous problem drinking/drug use upon return to the US. or increase substance use as a means of coping with stress-related problems or attempting to manage traumatic stress reactions.

PTSD, depression, and alcohol and drug problems are often co-occurring in veterans. Both health and mental health providers should be alert to this and, as part of patient education, should inform returning veterans about safe drinking practices, discuss the relationship between traumatic stress reactions and substance abuse, and initiate preventive interventions to reduce drinking.

Evidence suggests that substance abuse recovery is made more difficult by concurrent PTSD, and it is important to provide routine screening for PTSD in alcohol and drug treatment programs. When an individual is experiencing problems with both substance abuse and PTSD, it is important to address both disorders in an integrated fashion. Individuals should be helped to understand both problems and their relationship, and relapse prevention programming should address coping with traumatic stress symptoms without alcohol or drugs. Protocols for integrated treatment, such as the "Seeking Safety" trauma-relevant coping skills group intervention (Najavits, 2002), are now becoming available.

This brief clinical guide proposes a simple process, with proven accuracy, to screen individuals for substance abuse. This guide further suggests that care providers employ the screen in the three phases of pre-deployment, in the combat zone, and upon evacuation. The data gained at each juncture will help the clinician's decision making process in clarifying the contribution of substance use to a muddled clinical picture, taking appropriate treatment steps, forestalling some unnecessary evacuations, and prompting the best match between the individual's needs and the military mission.

References

- National Institute on Alcohol Abuse and Prevention. Unpublished data from the 1992 National Longitudinal Alcohol Epidemiologic Survey of 42,862 US adults aged 18 or older.
- Dawson, D. (2000). US low risk drinking guidelines: An examination of four alternatives. *Alcoholism Clinical and Experimental Research*, 24, 1820-1829.
- Friedman, P.D., Saitz, R., Gogineni, A., Zhang, J.X., & Stein, M.D. (2001). Validation of the screening strategy in the NIAAA. Physicians' Guide to Helping Patients with Alcohol Problems. *Journal of Studies on Alcohol*, 62, 234-238.
- Najavits, L.M. (2002). *Seeking safety: A treatment manual for PTSD and substance abuse*. New York: Guilford.

Additional Resources

- National Institute on Alcohol Abuse and Alcoholism: <http://www.niaaa.nih.gov/>
- National Institute on Drug Abuse: <http://www.nida.nih.gov/>
- National Clearinghouse on Alcohol and Drug Information: <http://www.health.gov/>
- Army Center for Substance Abuse Programs with links to world-wide ASAP locations: <http://www.acsap.army.mil/>