

**POCKET  
GUIDES**



# **MENTAL HEALTH PLACEMENTS**

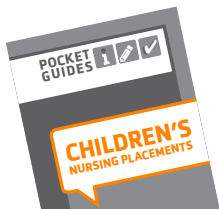
**Angelina Chadwick, Elizabeth  
Tudor, Maxine Womack and  
Luke Woodhouse**

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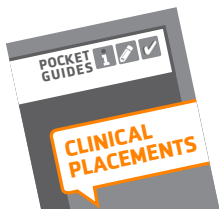


# **MENTAL HEALTH PLACEMENTS**

## Pocket Guides



**"A very useful, well-written and practical pocket book for any level of student nurse preparing for clinical placement. This book is also a great resource for lecturers and mentors to have, to help students get the most out of their placement time." ★★★★★**



**"This is such a useful guide that has just the right amount of need to know info for student nurses on clinical placement, as well as loads of little tips scattered throughout. A must-have for student nurses on placements!" ★★★★★**



**"Full of everything you need to know as a student nurse on placement. Written by students for students. Helpful little references to help with abbreviations and common medications. A must for any student about to head on placement." ★★★★★**



Forthcoming:



**POCKET  
GUIDES**



# **MENTAL HEALTH PLACEMENTS**

**Angelina Chadwick, Elizabeth Tudor,  
Maxine Womack and Luke Woodhouse**  
*University of Salford*



Lantern

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The authors and publisher have made every attempt to ensure the content of this book is up to date and accurate. However, healthcare knowledge and information is changing all the time so the reader is advised to double-check any information in this text on drug usage, treatment procedures, the use of equipment, etc. to confirm that it complies with the latest safety recommendations, standards of practice and legislation, as well as local Trust policies and procedures. Students are advised to check with their tutor and/or practice supervisor before carrying out any of the procedures in this textbook.

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# Preface

This pocket guide, part of a series from Lantern Publishing, is aimed specifically at mental health student nurses and will help prepare you for your practice placements within mental health environments. It has been compiled by two former mental health student nurses who are both working in full-time posts as staff nurses (MW and LW); a lecturer in mental health with many years' experience in clinical practice (AC); and a Practice Education Facilitator in a local mental health trust whose role is to actively support student nurses in practice (ET). This pocket guide is therefore written with first-hand experience and should guide you when you go out into practice.

Within mental health settings there are various terms for patients: for example, service user, client and patient. For the purposes of this book we will use the term 'patient'.

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# Acknowledgements

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The publishers would like to thank Kirstie Paterson and Jessica Wallar, authors of *Clinical Placements*, the first in the Pocket Guide series, and Kath MacDonald, their editor, for permission to use some of the content from their book as well as the overall framework.

# Abbreviations

## Abbreviations specific to mental health

|       |   |
|-------|---|
| ADHD  | attention deficit hyperactivity disorder    |
| AMHP  | approved mental health professional         |
| AWOL  | absent without leave                        |
| BP    | bipolar disorder                            |
| BPD   | borderline personality disorder             |
| CAMHS | child and adolescent mental health services |
| CBT   | cognitive behavioural therapy               |
| CMHN  | community mental health nurse               |
| CMHT  | community mental health team                |
| CPN   | community psychiatric nurse                 |
| CTO   | compulsory treatment order                  |
| DBT   | dialectic behavioural therapy               |
| DoLS  | Deprivation of Liberty Safeguards           |
| ECT   | electroconvulsive treatment                 |
| EIT   | early intervention team                     |
| FMH   | forensic mental health                      |
| HTT   | home treatment team                         |
| MCA   | Mental Capacity Act                         |
| MDD   | major depressive disorder                   |
| MDO   | mentally disordered offenders               |
| MHA   | Mental Health Act                           |
| MHRT  | mental health review tribunal               |
| MI    | motivational interviewing                   |
| MSE   | mental state examination                    |
| OCD   | obsessive–compulsive disorder               |
| PD    | personality disorder                        |
| PIT   | personal infrared transmitter               |
| PTSD  | post-traumatic stress disorder              |

|      |                                 |
|------|---------------------------------|
| RC   | responsible clinician           |
| RMN  | registered mental health nurse  |
| SOAD | second opinion appointed doctor |
| SPOE | single point of entry           |
| WRAP | wellness recovery action plan   |

### **Generic abbreviations**

|                |  |
|----------------|--|
| A&E            | accident and emergency ( <i>see also</i> ED) |
| ABC            | airway, breathing, circulation               |
| ADLs           | activities of daily living                   |
| AVPU           | alert, verbal, pain, unresponsive            |
| BLS            | Basic Life Support                           |
| BP             | blood pressure                               |
| <i>C. diff</i> | <i>Clostridium difficile</i>                 |
| COPD           | chronic obstructive pulmonary disease        |
| CPCE           | computerised prescriber code entry           |
| CPR            | cardiopulmonary resuscitation                |
| CSU            | catheter specimen urine                      |
| CVA            | cerebrovascular accident                     |
| DNAR           | do not attempt resuscitation                 |
| DOB            | date of birth                                |
| DVT            | deep vein thrombosis                         |
| ECG            | electrocardiogram                            |
| ED             | emergency department                         |
| GI             | gastrointestinal                             |
| HR             | heart rate                                   |
| IM             | intramuscular                                |
| LOC            | loss of consciousness                        |
| MAR            | medicines administration record              |

|                |  |
|----------------|--|
| MDT            | multidisciplinary team                             |
| MRSA           | methicillin-resistant <i>Staphylococcus aureus</i> |
| MSU            | midstream specimen urine                           |
| NG             | nasogastric  |
| O <sub>2</sub> | oxygen   |
| OPD            | outpatient department                              |
| OT             | occupational therapy                               |
| PE             | pulmonary embolism                                 |
| PPE            | personal protective equipment                      |
| SW             | social worker                                      |
| TIA            | transient ischaemic attack                         |
| TPR            | temperature, pulse, respiration                    |
| UDS            | urinary drug screen                                |

Confusion in the use of abbreviations has been cited as the reason for some clinical incidents. Therefore you should only use these abbreviations with caution and only in line with local Trust policy and clinical governance recommendations, which may vary between departments.

# Getting there

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## 14.1 Assessment

### Risk assessment

At the core of any mental health practice is the assessment of a patient's risk. This will inform any intervention that needs to be undertaken by a nurse. This is using a formatted risk assessment tool approved by the Trust. Check your local Trust policy for its risk assessment and management tool.

Generally, risk assessments cover four different domains:

- **Risk to self:** where a person is a self-harm risk or suicide risk.
- **Risk to others:** where a person could be violent and even injure others.
- **Risk of neglect:** where a person maybe fails to wash themselves, eat or even drink fluids.
- **Risk of vulnerability/exploitation:** where a person is at risk of being taken advantage of, in terms of losing their money to others or being sexually exploited/abused.

### Mental State Exam (MSE)

Another assessment that a nurse carries out is the assessment of a patient's mental state, through the objective description and subjective observation of a patient. This can be done in a formal way through discussion in a 1:1 session or through informal conversations. The areas that an MSE considers are:

**Appearance and behaviour:** posture, facial expression, mannerisms, whether fidgeting or sitting still, level of eye contact.

**Mood:** objective description from the patient on how they are. Rating scales from 1–10 could be used. Are they euthymic

(normal mood) or labile (changing rapidly)? Is the mood appropriate for the circumstance? For example, if someone is tearful after hearing bad news, this is considered a normal reaction.

**Affect:** is the patient's current emotional state appropriate? Are they bright, flat or superficially settled?

**Speech:** is the speech at a normal, steady pace? Is the patient only responding in short quick statements? Is there any pressure to the speech (talking at a fast pace)?

**Thoughts:** through open questioning you can discuss what is currently on their mind. Are there any suicidal thoughts? Any hopelessness or thinking they should no longer be cared for?

**Perceptions:** is the patient experiencing any perceptual disturbances, such as hearing voices or seeing things that are not there? Are they experiencing any paranoia?

**Capacity:** does the patient have capacity to make their own decisions at the time of examination?

This is not an exhaustive list of things to consider. It is important to note these examinations against previous MSE, to see whether there is a baseline MSE or any sudden change in their presentation, which could cause concern.

## Observations

On the ward, every patient needs to be observed by staff and legally recorded. These observations come in different forms. Each level of observation is assessed based on the person's level of risk. Check your local observation policy for the different recorded levels and reasons for putting someone on different observation levels.



Some examples of observation levels include:

1:1 (one to one) – this is where a patient has to be with a staff member at all times (this can be at one of two different levels, either within eyesight or within arm's length).

1:5 (one in five) – a patient is to be observed every 5 minutes.

1:15 (one in fifteen) – a patient needs to be observed once every 15 minutes.

### Nursing models and frameworks

There are many different nursing assessment models and frameworks. One that is commonly used is the Nursing Process with its four elements of assessment, planning, implementation and evaluation (APIE). Sometimes goal setting is used with specific, measurable, achievable, realistic and timely (SMART) goals. Another is the activities of daily living (Roper–Logan–Tierney) model; this is used in areas more led by physical need, but can also be used within mental health settings.

There are specific mental health models, which involve more holistic approaches, such as the biopsychosocial model. Some practice areas have devised their own approaches, so before you attend your placement area find out what they use and do some further reading around it.



#### Notes

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## 14.2 Drug administration

Within your mental health placement area, you will find that registered nurses administer medicines, usually from the treatment/clinical room. Patients are individually invited to receive their prescribed medication in this manner within a quiet area, to maintain safety and uphold their privacy.

It is crucial you are aware that as a student you NEVER administer medicines to patients unless directly supervised by a registered nurse. The Royal Pharmaceutical Society (2019) in conjunction with the Royal College of Nursing has provided professional guidance on the administration of medicines in healthcare settings.

The nine rights (the 9 Rs) of drug administration below are steps and questions, which you need to consider, minimising the risk of making any medication administration errors.

| The 'Right'          | Action  |
|----------------------|---|
| Right <b>patient</b> | Check the identity of the patient – ask for full name and verify by their wristband and medicines administration record (MAR). In mental health settings and nursing homes, patients may be unable to confirm their identity. Follow the local policy in terms of verifying their identity, which may include the use of photographs of the patient attached to the MAR.  |
| Right <b>drug</b>    | Check the label on medicine container to be dispensed against the name written on a MAR or alternatively the computerised prescriber order code entry (CPOE). It is crucial to check the expiry date on the medicine container to ensure it is in date.<br><br>The right medication is one that the patient is not allergic to, so you must ask the patient if they are aware of any allergies they may have. If not, you should document this as 'none known'. |

| The 'Right'                | Action   |
|----------------------------|--|
| Right <b>route</b>         | Check the route for administration of the medication on the MAR and check it is in the correct form for the prescribed route. Check that the patient can take the medication via the prescribed route.   |
| Right <b>time</b>          | Check the medicine is administered at the prescribed time with the correct interval between doses, since some medicines may be given several times over the course of the day. Medicines must also be prepared in a timely manner ready for the prescribed time of administration. The right rate needs to be considered here, e.g. in the case of intravenous fluids. |
| Right <b>dose</b>          | Check the prescribed dose on the MAR against the label of the medicine to be dispensed. Check that the prescribed dose is within the known dosage range.   |
| Right <b>documentation</b> | Check that you have the correct patient's MAR before administration of medicines. Once the medication has been administered the nurse must sign the MAR and if required, use the correct code if, for example, a patient has refused to accept the medication. Documentation is an important legal responsibility.   |
| Right <b>action</b>        | Check the medicine to be administered is for the right reason. The nurse administering the medicine should explain to the patient the action of the medication and what it is for.   |
| Right <b>form</b>          | Check the container of the medication to be administered, to be sure that it is in the correct form for the prescribed route.  |
| Right <b>observations</b>  | The nurse should monitor the patient to ensure that the medication has the correct response. This may require physiological observations to be undertaken and recorded or the assessment of blood glucose levels.  |

Elliott, M. and Liu, Y. (2010) The nine rights of medication administration: an overview. *British Journal of Nursing*, 19(5): 300–5.

## Routes of administration

**Enteral:** this route uses the gastrointestinal (GI) tract for absorption of medicines. Examples include oral administration (tablets, liquids) which are swallowed or via a feeding tube such as a nasogastric (NG) tube.

**Parenteral:** this route bypasses the GI tract, e.g. injections.

**Injection:** types include

- subcutaneous (medicine goes into the fatty tissue beneath the skin)
- intramuscular (medicine goes into the muscle)
- intravenous (injection/infusion where medicine goes into the vein)

**Inhaled:** nasal sprays and inhalers.

**Mucous membrane routes:** medicines which are not absorbed by the GI tract and are instead applied to the mucous membranes, e.g. vaginal, rectal, buccal (medicine is held against the inside of the cheek); sublingual (dissolves under the tongue).

**Topical:** medicines which are applied directly to the skin, e.g. creams, ointments, transdermal patches.

| Abbreviation | Meaning       |
|--------------|---------------|
| IM           | Intramuscular |
| Inh          | Inhaled       |
| IV           | Intravenous   |
| Neb          | Nebuliser     |
| O            | Oral          |
| PR           | Per rectum    |
| PV           | Per vagina    |

| Abbreviation | Meaning      |
|--------------|--------------|
| S/C          | Subcutaneous |
| S/L          | Sublingual   |
| TOP          | Topical      |

## Side-effects

When administering medicines to mental health patients it is important that you assess whether they are experiencing any side-effects. These can include akathisia, increased appetite or weight gain, or tardive dyskinesia, and you will need to monitor and respond to any side-effects.

One tool to examine these side-effects is the Liverpool University Neuroleptic Side-Effect Rating Scale (LUNSERS) which scores the response from the patient on the side-effects they are experiencing whilst taking their prescribed medication.

Often prescribers will use different terms for the administration of medications. Some common medical shorthand (derived from Latin) for medication administration is shown below:

|       |  |
|-------|--|
| BD    | twice daily  |
| Mane  | in the morning   |
| Nocte | at night   |
| PRN   | as required  |
| Px    | prescription   |
| QD/OD | every day/once daily   |
| QDS   | four times daily   |
| TDS   | three times daily  |
| Ṫ     | One dose of prescribed medication that is not measured in mg/mcg, e.g. Senna<br>ṪṪ means two Senna tablets |



## Tips for administering drugs

- Be certain of the patient's identity and check whether the patient has any allergies before you administer medication. Most medication cards should have a photograph of the patient on the front.
- Patients with an allergy should have an alert on the front of their medication card and on the patient main electronic record system, e.g. PARIS.
- Never give a medicine unless you know what it's for – some medicines are used for more than one condition so check the *British National Formulary* (BNF) to make sure it's the right dose.
- Sometimes prescribers' handwriting can be hard to read, making it difficult to tell exactly what medicine has been prescribed – get the prescriber to rewrite the prescription and confirm this before administering the medication.
- Sign for any medicine you have administered immediately to reduce risk of a drug error – but ensure that the patient has taken the medicine before you sign for it.
- Do not dispense (pot) the medication until the patient is present at the clinic.
- Document reasons why medications were not administered – for example, if a patient refuses – according to local policy.
- If in any doubt over the prescribed medication: **DO NOT ADMINISTER.**



## Notes

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## 14.3 Drug calculations

Administering drug calculations is a task that nurses perform many times every day so it is essential that you calculate medicine dosages accurately and confidently. Like all skills, this is a skill that takes a lot of time and practice to develop so take every opportunity to practise.

### Tablets and capsules

$$\text{No. of tablets} = \frac{\text{What you want (dose prescribed)}}{\text{What you've got (dose per tablet/capsule)}}$$

#### Example

*40 mg of fluoxetine is prescribed. The stock dosage is 20 mg. How many capsules should be given?*

$$40 \text{ mg} / 20 \text{ mg} = 2 \text{ capsules}$$

### Liquids and syrups

$$\text{Volume to be given} = \frac{\text{What you want (dose prescribed) x volume of liquid}}{\text{What you've got (dose of drug in stated volume)}}$$

#### Example

*200 mg of chlorpromazine is prescribed. The stock dosage is in liquid form of 100 mg/5 ml. How many millilitres should be given?*

$$200 \text{ mg} / 100 \text{ mg} \times 5 = 10 \text{ ml}$$

| Unit        | Abbreviation | Equivalent       | Abbreviation |
|-------------|--------------|------------------|--------------|
| 1 kilogram  | kg           | 1000 grams       | g            |
| 1 gram      | g            | 1000 milligrams  | mg           |
| 1 milligram | mg           | 1000 micrograms  | mcg*         |
| 1 microgram | mcg*         | 1000 nanograms   | ng*          |
| 1 litre     | L or l       | 1000 millilitres | ml           |
| 1 mole      | mol          | 1000 millimoles  | mmol         |
| 1 millimole | mmol         | 1000 micromoles  | mcmol        |

\*It is recommended that micrograms and nanograms should never be abbreviated.

## Conversions

Sometimes the prescribed dose and the stock are different. The dosage calculation should be worked out in the same unit so that they are still the same strength.

### Example

*Convert 0.5 milligrams into micrograms*

- Micrograms are smaller than milligrams so multiply by 1000
- Therefore, 0.5 milligrams  $\times$  1000 = 500 micrograms

*Convert 500 micrograms into milligrams*

- Milligrams are larger than micrograms so divide by 1000
- Therefore, 500 micrograms  $\div$  1000 = 0.5 milligrams

Do the calculation in your head first, or written down on paper – then check with a calculator.



## 14.4 Observations

### Vital signs – NEWS

As a student nurse you may be asked to take a set of vital signs on patients. Patients in mental health settings should always have their vital signs recorded on admission and then dependent on clinical presentation. This will vary at times, from patients commencing on medication, which will require monitoring of their BP and temperature, to others who become physically unwell, at which time you will need to monitor all their vital signs. It sounds obvious but do not make numbers up! If you aren't sure how to take a measurement, always ask. However, if possible, check a manual reading if it doesn't feel right to you and if the results are not within the normal range for that patient.

This is the order of the main vital signs as laid out by the NEWS chart (see inside front cover).

#### *Respiration rate:*

- Count for a minute how many breaths your patient takes. Remember that if you tell them what you are doing, they may subconsciously change their breathing frequency or pattern.
- A normal respiration rate is between 12 and 20 respirations per minute.

#### *Oxygen saturation level:*

- When assessing this component it is also important to record if the patient is on any oxygen or if they have any past medical history that may pertain to their results (i.e. COPD, etc.).
- Peripheral oxygen saturation ( $SpO_2$ ) is an estimation of the oxygen saturation level, usually measured with a pulse oximeter. A normal  $SpO_2$  is in the range 94–99% (on air).
- Colour – is the patient's skin pink, or is there a blue tinge to the lips, tongue or nails? (implies lack of oxygen).

### **Blood pressure:**

- Always check that you are using the correct blood pressure cuff on a person before taking the measurement, either manually or by a machine.
- Large or very small arms may need a non-standard cuff.
- If you are unhappy with a reading check the other arm for comparison.

### **Heart rate:**

- This is often checked with the vital signs machine.
- It is also a good idea to check the pulse manually in order to feel for the strength, regularity and rate.

### **ACVPU (alert, new confusion, verbal, pain, unresponsive):**

- Check the patient's neurological status. Are they responding properly to you?
- Has the patient's mental state changed? Do they show new signs of confusion, disorientation or delirium?
- Are they responsive to verbal stimulation, pain stimulation or simply unresponsive?

### **Temperature:**

- Double-check a temperature reading if the patient's temperature is outside the normal range or if the thermometer appears faulty.
- If a patient is recording a very low temperature (e.g. hypothermia), a core (rectal) temperature may be required after checking another thermometer.

Familiarise yourself with the NEWS chart on the inside front cover of this guide, and always ask your practice supervisor or a registered nurse questions if you are not sure how to complete it properly.

**Remember:** if vital signs are not within normal range it is important that you inform your nurse or the responsible registered nurse, as you are working under their delegation.

Reference: Royal College of Physicians. *National Early Warning Score (NEWS) 2: Standardising the assessment of acute-illness severity in the NHS*. Updated report of a working party. London: RCP, 2017. Available at: [bit.ly/NEWS-2](http://bit.ly/NEWS-2)

## 14.5 Skin assessment

Pressure sores/ulcers are an area of localised tissue damage caused by excess pressure applied directly to the skin, shearing and/or friction. Within mental health settings patients who are elderly may be at risk of pressure sores due to immobility or falls. Other patients may harm themselves (repeatedly), causing skin breakdown and wound complications.

Pressure sores can be painful, prolong hospital stay, become infected and (in extreme cases) be a contributing factor in a patient's death.

### *What are the risk factors for developing pressure sores?*

- Age (older people)
- Immobility or reduced mobility
- Malnutrition
- Loss of sensation – patients with reduced sensation might not be able to alter their position themselves, so it's important to check skin for any redness or signs of skin breakage
- Vascular disease
- Existing restrictions, injuries or recent surgery
- Moisture on skin, e.g. incontinence and excessive perspiration
- Ill-fitting equipment aids which do not provide appropriate pressure relief.

### *Signs of pressure ulcer/sore development – look out for:*

- Persistent erythema (redness)
- Non-blanching erythema – this means that when pressed, the area does not turn white
- Blisters
- Skin may appear shiny or discoloured
- Localised heat
- Localised oedema (swelling)
- Vulnerable areas: heels, sacrum, elbows, back of skull, shoulders, toes.

## Waterlow

The Waterlow scale is an example of a structured scoring tool used to identify people at risk of developing pressure sores whilst in hospital (see inside back cover). It involves assessing the patient's skin and identifying additional factors which may increase a patient's overall risk of developing a pressure ulcer. Other tools are available, e.g. Braden risk assessment tool.

Patients who are identified as being more vulnerable to skin breakdown will be encouraged or assisted to change their position regularly. Manual handling aids such as specialist mattresses and cushions can be used to relieve pressure by evenly redistributing the weight of a patient.



### Notes

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## 14.6 Urinalysis

The analysis of urine can provide us with important information about a patient's health, which can assist in the diagnosis of medical conditions. It can also help us monitor the progression of disease and effects of treatment.

### Methods of collecting urine

- Natural voiding into a specimen pot.
- Transfer of urine from bedpan/urinal into a specimen pot.
- Midstream urinalysis (MSU) – genitals must be cleaned to reduce presence of contaminants such as bacteria. Ask the patient to pass urine into the toilet and then catch the middle part of the flow of urine into a sterile container and then pass the remaining urine into the toilet.
- A pad – some clinical areas have kits to enable a urine sample to be collected from an incontinence pad when a patient is unable to follow the above collection methods. The process involves placing a small sterile pad into a clean continence pad. Once the patient has urinated, the pad can be squeezed and a syringe can assist in aspirating the sample. The kit has detailed instructions for use, including the maximum duration that the testing pad can be left in place.
- Catheter specimen of urine (CSU) – clean sampling port of catheter with alcohol-based swab and allow it to dry for 30 seconds. If using a needle-less system, insert syringe into port and aspirate urine (approximately 10 ml). Some ports may require a needle and syringe. Insert needle into port at 45° angle, aspirate and remove needle. Sometimes there isn't enough urine in the catheter tubing to extract, so you may have to clamp the tubing to allow enough urine to accumulate for collection. Remember to unclamp the tubing afterwards to allow drainage to continue.
- 24-hour urine collection – used to assess kidney function by collecting and assessing urine collected over a 24-hour period.

## Physical appearance

Before using a dipstick (reagent) test to analyse urine, consider the colour, clarity and smell of the sample.

| Colour   |   |
|--|---|
| Light yellow or straw colour                   | Normal  |
| Dark yellow                                    | May indicate patient is dehydrated  |
| Bright red or reddish-brown                    | May suggest blood in the urine (haematuria)   |
| Brown–green or strong yellow                   | May suggest bilirubin is present, which can be indicative of liver or gall bladder problems   |
| Clarity  |   |
| Clear  | Normal  |
| Cloudy or containing small particles of debris | May be due to presence of pus, protein or white blood cells, which can be indicative of infection, kidney stones or urinary stasis                            |
| Smell  |   |
| Very little smell                              | Normal  |
| 'Fishy' smell                                  | May indicate presence of infection, or that a sample has been waiting too long to be tested – a sample should be tested within 2 hours of collection          |
| Sweet or fruity smell                          | May suggest presence of ketone bodies which are by-products of fat metabolism and may indicate patients who have been fasting or have diabetic hyperglycaemia |



### Top tip

Some foods and medications can produce certain smells (e.g. asparagus) or can alter the colour of urine (e.g. beetroot).

## Urinary drug screen (UDS)

During your placement you may be required to collect a sample of urine and test it to assess whether a patient has taken an illicit substance or non-prescribed medication. This could be because you're based at a Drug and Alcohol inpatient detox unit or because a patient has returned from leave and there has been a change in presentation.

A drug screen may need to be observed by a member of staff to ensure that the test is accurate, and the patient has provided a sample of their own urine for testing.

Drug screens can test for substances such as amphetamine, cocaine, THC (cannabis), opiates, benzodiazepines or methadone.

It is important to check the patient's prescribed medication which may have an effect on this result. For example, if a patient is not prescribed medication such as lorazepam but their UDS shows they have benzodiazepines in their system, it indicates they have taken some illicit benzodiazepines whilst on leave.

Below are results of a drug screen. It is important to check the instructions of the UDS you are using, as indications may vary.

