A. Purpose of This Document

The purpose of this training is to provide school administrators, educators, and nurses with a systematic approach to recognizing and evaluating individuals in the academic environment who are using and are impaired by drugs, in order to provide early intervention.

This training is not intended to qualify participants to be drug recognition experts (DREs) or drug recognition technicians (DRTs); rather its purpose is to aid in the evaluation and documentation of those suspected of using drugs and impaired by drugs. For the purpose of this training, the definition of a drug is “any substance that alters perception or behavior reducing that individual’s ability to function appropriately in the academic environment.”

An increasing body of data suggests that an appreciable percentage of inappropriate behavior may be due to the influence of drugs and alcohol, either alone or in combination. Estimates of this appreciable percentage vary, but all estimates agree that the average professional educator will almost inevitably encounter impaired individuals from time to time. It is important, therefore, that the educator be able to recognize when he or she has encountered an impaired individual and understand how to deal with this situation in the academic environment.

This Administrator Guide facilitates the planning and implementation of the training. The guide provides an overview of the course of instruction, the documents, and other materials that make up the training’s curriculum package. It describes the administrative requirements and offers guidelines for discharging those requirements satisfactorily. It outlines the preparatory work that must be accomplished before the training can be offered. It also describes recommended follow-up work that should be undertaken to ensure the effectiveness of this training.

Before addressing the details of this training, it is appropriate to emphasize one thing that the training will not do:

THIS TRAINING WILL NOT QUALIFY AN OFFICER OR OTHER PARTICIPANT TO SERVE AS A DRUGRECOGNITION EXPERT (DRE)

The subject matter covered touches upon some (but not all) of the factors a DRE considers in examining a drug-impaired individual.

B. Overview of the Training

1. For whom is the training intended?

This training is designed primarily for administrators, educators, school resource officers, counselors, nurses, and education trainers in the academic setting. The participant who completes the full 16 hours of training should be able to administer and
interpret various impairment tests. The participant should be fully conversant with the procedural mechanics of the tests and with the interpretation of clues for assessing impairment.

2. What are the purposes of the training?

The purpose of the training is to improve an individual’s ability to (1) recognize those who may be under the influence of drugs other than alcohol and (2) to take appropriate action when encountering such behavior. Note that the purpose of this training does not require the attendees to develop the ability to distinguish what type of drug is responsible for the observed impairment. The participants should become more adept at recognizing the possible presence of some drug category other than alcohol, or a medical condition, and at conveying a credible basis for that suspicion.

3. What will the participants get out of the training?

The participant who successfully completes the training will be able to identify:
- The term drug in the context of this course.
- The concept of drugs that impair in the academic environment.
- The drugs of choice within a community setting.
- The role of simple divided attention tests in accessing impairment.
- The observable effects of each of the major drug categories.
- The effects likely to result from various drug combinations.
- The importance of policies and procedures for dealing with cases involving drug-impaired individuals in the academic setting.
- The drug categories.
- Medical conditions and other situations that can produce similar signs of impairment.
- Appropriate procedures for dealing with drug-impaired or medically impaired individuals in the academic environment.

4. What subject matter does the training cover?

The principal content topics include the following:

(1) Concept of drugs in the education environment. Basically, as far as the professional educator is concerned, a drug is a substance that impairs an individual’s ability to function appropriately in an academic environment.

(2) Magnitude and scope of drug use and abuse in our education system, and the involvement of drugs in impaired incidents.

(3) Role of eye examinations in disclosing the possibility of drug impairment, and in suggesting the possible category or categories of drugs, or medical conditions causing an individual’s impairment.
(4) Observable effects of each of the major drug categories.

(5) Effects likely to result from various drug combinations.

(6) Individual jurisdiction’s procedures for dealing with cases involving individuals suspected of drug influence or medical conditions.

5. What activities take place during the training?

Day 1 of the training relies primarily on instructor-led presentations. This is in keeping with its focus on information development, rather than skill development. Day 2 of the training, if utilized, relies on instructor/participant interaction to develop the skills needed to complete this training.

6. How long does the training take?

The training is designed to be divided into two eight-hour blocks of instruction. The first eight hours are focused on classroom training. The second eight hours are focused on developing practical skills.

Note: Due to the availability of the participants and individual school needs, the training may be completed in one day utilizing portions of the curriculum that would be most beneficial to the school. If an abbreviated training is conducted (less than 8 hours), then the training is not a true representation of DITEP. Any certificates of completion or CLE credits should not be identified as DITEP, which is either an 8-hour or 16-hour training course. Depending on the training conducted, a certificate can be presented for attending Day 1 and a second certificate for Day 2. For those jurisdictions that offer the training in its entirety, one certificate is sufficient.

A typical schedule is a class beginning at 8:00 AM and concluding at 5:00 PM each day. A one-hour lunch period and hourly breaks of ten minutes are accommodated in the schedule. It is not intended that the schedule be without flexibility. The course administrator is allowed the flexibility to adjust the schedule based on the needs of the participants and/or instructors. A class roster is recommended for each day of the training.

C. Overview of the Curriculum Package

In addition to the Administrator Guide, the curriculum package for this training includes an Instructor Guide, Participant Manual (Day 1 and Day 2), and PowerPoint slides.
1. Instructor Guide

The Instructor Guide is a complete and detailed guide to what the training covers and how it is to be taught. It is organized into 11 sessions, each corresponding to one of the course’s training sessions.

Each session consists of a cover page, an outline page, the lesson plans, and images of the PowerPoint slides referenced in the lesson plans.

The cover page presents the session’s title and the total instructional time recommended to complete the session.

The outline page lists the specific learning objectives of the session; that is, what the participants will be able to do once they have successfully completed the session’s learning activities.

It also lists the session’s major content segments and the principal types of learning activities that take place during the session.

The lesson plans themselves are arranged in the following format:

- The training aids (time frames, visual aids, etc.)
- The content, or an outline of what is to be taught.
- The notes to the instructor. They provide guidance concerning how the content is to be taught. The “Instructor Note” specifies, for example, how the instructor is to present the material, involve the participants in the presentation, oversee their practice and ensure that they adequately cover the training material.

Typical entries the Instructor Note may contain:

- The approximate amount of time to be devoted to each content segment.
- Indications of points requiring special emphasis.
- Specifications and procedures for the hands-on practice opportunities
- Personal notes.
- Questions that can be posed to the participants to better involve them.
- Examples and other techniques for clarifying the concepts being presented.

The Instructor Guide serves as a means of preparing the instructor to teach the course. Every instructor should review the entire set of lesson plans to become familiar with the content and learning activities and develop a clear understanding of how the course fits together. Instructors are expected to become thoroughly familiar with every session they are assigned to teach, to assemble all materials and other instructional equipment referenced in the lesson plans, and to augment the instructor notes as necessary to ensure that individual teaching styles and experiences are applied to the content and learning activities.
The Instructor Guide serves as an in-class reference document for helping to maintain the sequence and pace of presentations and other learning activities; however, the information contained in the outlines should not be read verbatim to the participants.

2. Visual Aids

Types of visual aids that can be used in this training include:
- Dry-Erase board/flip-chart presentations (which are indicated in the instructor notes of the lesson plans and are self-explanatory).
- Video segments and/or website links to recommended videos.
- Computer presentations (PowerPoint).

The visuals (PowerPoints) are displays of graphic and/or narrative information that emphasize key points and support the instructor’s presentation. Each PowerPoint slide image is included in the Instructor Guide and Participant Manual to aide in referencing the slide during the presentations.

3. Participant Manuals

The Participant Manual is the principal reference source for this training. It contains summaries of the main points of the training’s content, and guidance for further study and review by the participant.

The Participant Manual will be useful for previewing the sessions, and for studying the subject matter for preparation for the final examination. The Participant Manual will also be useful after the formal instruction ends and the newly acquired information is utilized.

4. Final Examinations

Some schools and school districts may require a final examination to assist in obtaining continuing education credits or something similar to fulfill their training obligations. To assist with this, two written examinations are included and are available for copying and use at the end of this Guide. One is for a one-day (8 hour) training and the second is for the two-day (16 hour) training. The examinations are multiple choice, and an answer key is provided.

D. General Administrative Requirements

1. Delivery Contexts

This training is compatible with a wide variety of delivery contexts. The International Association of Chiefs of Police (IACP) designed the training as a stand-alone course to provide education professionals with the information needed to recognize and evaluate individuals in the academic environment who are using and impaired by drugs, to provide early intervention when needed.
2. Facility Requirements

The training requires a standard classroom, equipped with a screen, dry-erase board and/or flipchart, appropriate projector, and adequate seating/table space for all participants. If Day 2 of the training is utilized, the facility should also provide for a separate room that is capable of being darkened for segments of training that require practical exercises.

3. Instructor Qualifications

At a minimum, the instructor(s) for this training should be a DRE who is an SFST instructor or a DRE with other verifiable instructor training experience. Whenever possible, DRE instructors should be utilized for the training and must be endorsed by the DEC Program state coordinator and certified as a DRE/DRE instructor.

It is strongly suggested that the instructor(s) have attended and observed a DITEP training course to be familiar with the content, materials, and subject matter.

The DEC Program state coordinator must approve the instructor. The DITEP instructor endorsement should not be automatically or casually awarded.

The mere fact that a person attended a DITEP course and instructed a class does not guarantee that he or she is qualified as a DITEP instructor. He or she must demonstrate acceptable performance as a trainer for the state coordinator to endorse and approve the instructor.

Instructor certificates (if issued) are the responsibility of the individual states and are not mandatory. The Office of Highway Safety and/or the DEC Program state coordinator may provide DITEP instructor certificates.

4. Class Size Considerations

The method of instruction is designed to accommodate a reasonably large class. Instructors should limit the class size based on their ability to allow participants sufficient opportunity to interact with instructors.

E. Planning and Preparation Requirements

The planning and preparation requirements for this training are the standard requirements associated with any classroom training which include:

1. Select only qualified instructors and assign them to deliver specific sessions of the training. All instructors should review all portions of the training, so they understand how their assignments fit into the course.
2. Prepare and review necessary visuals as needed.

3. Obtain necessary instructional equipment. Ensure equipment is working properly and be familiar with it.

4. Arrange the classroom so that all participants will have a clear view of the instructor, video screen, dry-erase board, and other visuals.

5. Obtain (or reproduce) sufficient copies of the Participant Manuals for the participants. Typically, this is done by the local school or jurisdiction hosting the training.

F. Follow-Up Requirements

It is important that both the delivery and impact of this training be evaluated. Evaluation of delivery focuses on the general question; What did the participants think of this training? Evaluation of the impact concerns itself with, how has the training impacted the education environment’s ability to detect and deal with drug impaired individuals?

Important data for evaluating training delivery can be obtained from the anonymous Participant’s Critique Form (included in the Instructor Guide). Each participant should be requested to complete and submit the form upon conclusion of the training.

Schools may wish to include records of each assessment completed by those who have attended DITEP training. The Administrator Guide provides a copy of a data collection form for recording a minimum of information. The intent of the data collection is to determine the effectiveness of the training. The DEC Program state coordinator should be notified of each training conducted to ensure that proper data is collected and reported in the state’s DRE annual report. The appendix to this guide contains sample forms for collecting data.

G. Guidelines for Preparing Post-Course Evaluation

During the final session of instruction of the training, each participant is expected to complete the anonymous participant’s critique form. The DEC Program state coordinator (or designee) may choose to compile the information into a summary report for future use.

A participant’s critique form is provided to document the participant’s initial rating of the training content and activities.

The following instructions are provided to guide review, analysis, and interpretation of participant’s comments:

1. Collect participant critiques
2. The rating choices are as follows:
   • Strongly agree
• Agree
• Neutral
• Disagree
• Strongly disagree

Analysis Procedures:
Step 1: Tabulate total number of responses in each category from the participant’s final course critiques.
Step 2: Tabulate the totals for each category on the final course administrator’s critique.
Step 3: Comments as appropriate (comments on positive and/or negative information concerning any aspect of the training is encouraged)

NOTE: A copy of the completed post-course evaluation report, appropriate comments and copies of the class rosters should be forwarded to the appropriate DEC Program state coordinator or their designee.

H. Requests for Information, Assistance or Materials

Formal requests for this training or law enforcement agencies interested in hosting or participating in a DITEP course should contact their state’s DEC Program state coordinator, or the IACP.

I. Continuing Education Units

Note: Continuing education units may be available through the hosting state’s educational office.
Drug Impairment Training for Education Professionals
Post Test – One Day Training

Name _______________________________________________

School Name _________________________________________

School District ________________________________________

Date_________________    Class Location _________________

1. The procedure which you should utilize in determining impairment by drugs will consist of a systematic and _____________ process.

   A. professional
   B. impartial
   C. standardized
   D. medical

2. The term “Drug” as used in this training, is defined as “Any substance that alters ___________ and ___________ reducing that individual’s ability to function appropriately in the academic environment.”

   A. perception / attitude
   B. behavior / appearance
   C. perception / behavior
   D. thinking / actions

3. The most commonly abused Central Nervous System Depressant is __________.

   A. Cocaine
   B. Ritalin
   C. Caffeine
   D. Alcohol

4. The most frequently abused drug other than alcohol is _____________.

   A. Cocaine
   B. Xanax
   C. Marijuana
   D. Oxycodone
5. Horizontal Gaze Nystagmus (HGN) is the inability of the eyes to fixate or gaze on a moving stimulus (target) as they ____________.  
   A. move up and down  
   B. move side to side  
   C. look straight ahead  
   D. look at the ground

6. The drug fentanyl is within the ____________ drug category.  
   A. Narcotic Analgesics  
   B. CNS Stimulant  
   C. CNS Depressant  
   D. Dissociative Anesthetic

7. Pupil sizes that are typically seen in a person impaired by fentanyl are ________.  
   A. normal  
   B. dilated (large)  
   C. fluctuating  
   D. constricted (small)

8. An indicator that may signal drug abuse is a ____________.  
   A. change in behavior  
   B. change in friends/associates  
   C. change in appearance  
   D. All the above

9. Adderall is a legal prescription drug from the ____________ drug category.  
   A. CNS Depressants  
   B. CNS Stimulants  
   C. Narcotic Analgesics  
   D. Dissociative Anesthetics

10. The primary psychoactive chemical in marijuana is _______________________.  
    A. Sinsemilla  
    B. Dronabinol  
    C. Delta-9-Tetrahydrocannabinol (THC)  
    D. Cannabinol (CBD)
Drug Impairment Training for Education Professionals

Post Test - Day One (Answer Key)

1. The procedure which you should utilize in determining impairment by drugs will consist of a systematic and (C) standardized process.

2. The term “Drug” as used in this training, is defined as “Any substance that alters (C) perception and behavior reducing that individual’s ability to function appropriately in the academic environment.”

3. The most commonly abused Central Nervous System Depressant is (D) Alcohol.

4. The most frequently abused drug other than alcohol is (C) marijuana.

5. Horizontal Gaze Nystagmus (HGN) is the inability of the eyes to fixate or gaze on a moving stimulus (target) as they (B) move side to side.

6. The drug fentanyl is within the (A) Narcotic Analgesic drug category.

7. Pupil sizes that are typically seen in a person impaired by fentanyl is (D) constricted (small).

8. An indicator that may signal drug abuse is (D) All the above: Change in behavior, Change in friends/associates and Change in appearance.

9. Adderall is a legal prescription drug from the (B) CNS Stimulants drug category.

10. The primary psychoactive chemical in marijuana is (C) Delta-9-Tetrahydrocannabinol (THC).
Drug Impairment Training for Education Professionals

Post Test – Two Day Training

Name ____________________________________________

School Name ______________________________________

School District ________________________________

Date__________________________ Class Location ____________

1. The definition of “drug” as it pertains to this training is any substance that alters _________ or _________, reducing that individual’s ability to function appropriately in the academic environment.

   A. Perception/learning
   B. Perception/behavior
   C. Functioning/comprehension
   D. Skills/attitude

2. Which of the following is NOT one of the drug categories covered in this training?

   A. Tricyclics
   B. CNS Depressants
   C. Cannabis
   D. CNS Stimulants

3. Valium and Xanax are drugs from which drug category?

   A. CNS Stimulants
   B. Narcotic Analgesics
   C. Dissociative Anesthetics
   D. CNS Depressants

4. Heroin, Fentanyl and Oxycodone are drugs from which drug category?

   A. CNS Stimulants
   B. Hallucinogens
   C. Narcotic Analgesics
   D. Dissociative Anesthetics
5. A drug that typically dilates (makes larger) a person’s pupils is _________.
   A. Heroin
   B. Methamphetamine
   C. Vicodin
   D. Xanax

6. Alcohol is metabolized by what body organ?
   A. Liver
   B. Brain
   C. Heart
   D. Kidney

7. Two drugs that may cause a person to an elevated blood pressure are _________.
   A. Heroin and Vicodin
   B. Marijuana and Alcohol
   C. PCP and Methamphetamine
   D. Ritalin and Cocaine

8. Hallucinations are primarily associated with which drug category?
   A. CNS Depressants
   B. Narcotic Analgesics
   C. Hallucinogens
   D. CNS Stimulants

9. Which of the following is not one of the clues for horizontal gaze nystagmus (HGN)?
   A. Lack of smooth pursuit
   B. Red, blood shot eyes
   C. Distinct and sustained nystagmus at maximum deviation
   D. Onset of nystagmus prior to 45 degrees

10. Normal pulse rate range of a non-impaired person as used in this training is _________.
    A. 40-60 bpm
    B. 50-70 bpm
    C. 60-80 bpm
    D. 70-90 bpm
11. A drug category that typically causes Horizontal Gaze Nystagmus (HGN) is ______.

   A. Cannabis
   B. Narcotic Analgesics
   C. CNS Stimulants
   D. CNS Depressants

12. For the Modified Romberg Balance test, how long is the person asked to estimate?

   A. 60 seconds
   B. 20 seconds
   C. 30 seconds
   D. 15 seconds

13. How far from the person’s face should the stimulus be held when performing the Horizontal Gaze Nystagmus test?

   A. 12-15 inches
   B. 10-12 inches
   C. 6-8 inches
   D. 4-6 inches

14. DRE stands for ______________.

   A. Drug Resource Examiner
   B. Drug Recognition Expert
   C. Drug Research Examination
   D. Drug Research Evaluator

15. Which of the following drugs typically cause a person to have constricted (small) pupils?

   A. Heroin
   B. Alcohol
   C. Adderall
   D. Methamphetamine

16. The primary psychoactive chemical in marijuana is ______.

   A. DXM
   B. THC
   C. STP
   D. MDMA
17. A drug from the narcotic analgesics drug category is _______.
   A. Methamphetamine  
   B. Cocaine  
   C. Ritalin  
   D. Buprenorphine

18. When handling illicit drugs, care should be taken to avoid absorbing the drugs through the skin. This is especially true with ________.
   A. Marijuana  
   B. Cocaine  
   C. Fentanyl  
   D. Hashish

19. Which drug category, or categories, causes red, bloodshot eyes?
   A. CNS Stimulants  
   B. Cannabis  
   C. Inhalants  
   D. B & C

20. When a person impaired by drugs cannot track an object in towards the bridge of the nose and cross their eyes, it is called ________.
   A. Rebound dilation  
   B. Lack of convergence  
   C. Eye drift  
   D. Nystagmus

21. Which drug category, or categories, typically lowers body temperature?
   A. CNS Stimulants  
   B. Dissociative Anesthetics  
   C. Hallucinogens  
   D. Narcotic Analgesics

22. The Walk and Turn and One Leg Stand tests are ________ tests.
   A. Divided attention  
   B. Divided judgement  
   C. Judgement measuring  
   D. Cognition judgement
23. Ingesting two or more drugs at the same time is called _______.

A. Pill-popping  
B. Polydrug use  
C. Poly-administration  
D. Pharming

24. Lack of convergence is typically associated with what drug category or categories?

A. All drug categories  
B. Cannabis  
C. CNS Stimulants  
D. Hallucinogens

25. Robo-Tripping is a slang street name for abusing what drug?

A. Xanax  
B. Marijuana  
C. Alcohol  
D. Dextromethorphan (DXM)
Drug Impairment Training for Education Professionals

Post Test - Day Two (Answer Key)

1. The definition of drug as it pertains to this training is any substance that alters _________ or __________, reducing that individual’s ability to function appropriately in the academic environment.

   A. Perception/learning
   B. **Perception/behavior**
   C. Functioning/comprehension
   D. Skills/attitude

2. Which of the following is NOT one of the drug categories covered in this training?

   A. **Tricyclics**
   B. CNS Depressant
   C. Cannabis
   D. CNS Stimulant

3. Valium and Xanax are drugs from which drug category?

   A. CNS Stimulants
   B. Narcotic Analgesics
   C. Dissociative Anesthetics
   D. **CNS Depressants**

4. Heroin, Fentanyl and Oxycodone are drugs from which drug category?

   A. CNS Stimulants
   B. Hallucinogens
   C. **Narcotic Analgesics**
   D. Dissociative Anesthetics

5. A drug that typically dilates (makes larger) a person’s pupils is __________.

   A. Heroin
   B. **Methamphetamine**
   C. Vicodin
   D. Xanax
6. Alcohol is metabolized by what body organ?
   
   A. Liver
   B. Brain
   C. Heart
   D. Kidney

7. Two drugs that may cause a person to have an elevated blood pressure are _______.
   
   A. Heroin and Vicodin
   B. Marijuana and Alcohol
   C. PCP and Methamphetamine
   D. Fentanyl and Oxycodone

8. Hallucinations are primarily associated with which drug category?
   
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   B. Narcotic Analgesics
   C. Hallucinogens
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9. Which of the following is not a clue for the Horizontal Gaze Nystagmus test?
   
   A. Lack of smooth pursuit
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14. DRE stands for _____________.

A. Drug Resource Examiner  
B. Drug Recognition Expert  
C. Drug Research Examination  
D. Drug Research Evaluator  

15. Which of the following drugs will typically cause a person to have constricted (smaller) pupils?

A. Heroin  
B. Alcohol  
C. Adderall  
D. Methamphetamine  

16. The primary psychoactive chemical in marijuana is _______.

A. DXM  
B. THC  
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   A. Xanax
   B. Marijuana
   C. Alcohol
   D. Dextromethorphan (DXM)
COURSE CRITIQUE
DRUG IMPAIRMENT TRAINING FOR EDUCATION PROFESSIONALS

Date__________________                        Location of Training ____________________

Day One / Day Two

Training Evaluation

1. The content was what I expected.

   Strongly Agree        Agree          Neutral          Disagree          Strongly Disagree

2. The instructors were knowledgeable about the subject matter.

   Strongly Agree        Agree          Neutral          Disagree          Strongly Disagree

3. The visuals could be seen easily.

   Strongly Agree        Agree          Neutral          Disagree          Strongly Disagree

4. I had no trouble hearing the speakers.

   Strongly Agree        Agree          Neutral          Disagree          Strongly Disagree

5. The timing of the presentation and the breaks were appropriate.

   Strongly Agree        Agree          Neutral          Disagree          Strongly Disagree

Content Evaluation

1. I can identify impairment from the seven drug categories in the academic environment.

   Strongly Agree        Agree          Neutral          Disagree          Strongly Disagree

2. I can state the steps and procedures to use in determining impairment of an individual.

   Strongly Agree        Agree          Neutral          Disagree          Strongly Disagree
3. I can list the observable impairing effects of each of the seven drug categories and common polydrug combinations.

   Strongly Agree    Agree    Neutral    Disagree    Strongly Disagree

4. I can discuss the need for policies and procedures for dealing with drug-impaired individuals in the academic setting.

   Strongly Agree    Agree    Neutral    Disagree    Strongly Disagree

5. I would rate the overall training as:

   Excellent    Good    Average    Fair

What portion(s) of the training did you feel was/were most beneficial?

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

What portion(s) of the training did you feel was/were least beneficial?

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

List any additional ideas, comments, and suggestions for this training.

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
Instructors

Please rank the following instructors on a scale of 1 to 5 (1 = Poor and 5 = Excellent) or N/A if it does not apply to the instructor (1 = Poor and 5 = Excellent):

<table>
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<th>Instructor Name</th>
<th>Facilitated an atmosphere conducive to learning</th>
<th>Familiarity with the subject(s) presented</th>
<th>Presented information in a manner which met the needs of all participants</th>
<th>Coaching ability in classroom &amp; practical exercises</th>
<th>Ability to answer questions</th>
<th>Tactfulness in correcting mistakes in practical exercises</th>
<th>Overall rating of the instructor</th>
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Please use the space below if you have any additional comments:

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Drug Impairment Training for Education Professionals – Administrator Guide
IACP 8/2023
Drug Impairment Training for Education Professionals

Class Roster

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Lead Instructor: ____________________________ Course Administrator______________________________
Day One

0800 - 0830 Session I - Introduction and Overview
  Section A-D
  Section E-J

0830 - 0900 Session II - Drugs in Society
  Entire Session

0900 - 0930 Session III - Overview of Alcohol
  Entire Session

0930 - 0945 Break

0945 - 1200 Session IV - Drug Identification, Categories & Their Effects
  0945 - 0955 Sections A - C - Definition of Drug
  0955 - 1030 Section D - CNS Depressants
  1030 - 1105 Section E - CNS Stimulants:

1105 - 1115 Break

1115 - 1200 Section F – Hallucinogens

1200 - 1300 Lunch

1300 - 1340 Section G - Dissociative Anesthetics
  1340 - 1420 Section H - Narcotic Analgesics

1420 - 1430 Break

1430 - 1510 Section I - Inhalants
  1510 - 1540 Section J - Cannabis
  1540 - 1550 Section K - Polydrug

1550 - 1600 Break (optional – at class discretion)

1600 - 1630 Session V - Policies, Procedures, Roles, and Contacting the Parents
  Entire Session

1630 - 1640 Session VI - References
  Entire Session

1640 - 1700 Questions - Discussion (Critiques)
  Test - Day One Material (optional)
### Day Two

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<td>Session VII - Eye Examinations</td>
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<tr>
<td>0800 - 0900</td>
<td>Horizontal Gaze Nystagmus</td>
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<td>Practice Sessions - All instructors serve as coaches to the participants.</td>
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<tr>
<td>0900 - 1000</td>
<td>Lack of Convergence</td>
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<td>Practice Sessions - All instructors serve as coaches to the participants.</td>
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<td><strong>1000 - 1015</strong></td>
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<td>1015 - 1100</td>
<td>Estimation of Pupil Size</td>
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<td>1100 - 1145</td>
<td>Session VIII - Vital Signs</td>
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<td>Practice Sessions - All instructors serve as coaches to the participants.</td>
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<tr>
<td><strong>1145 - 1245</strong></td>
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<td>1245 - 1600</td>
<td>Session IX - Divided Attention Testing</td>
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<td>1245 - 1330</td>
<td>Section A - Modified Romberg Balance</td>
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<td>1330 - 1415</td>
<td>Section B - Walk and Turn</td>
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<td>1415 - 1500</td>
<td>Section C - One Leg Stand</td>
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<td><strong>1500 - 1515</strong></td>
<td>Break</td>
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<tr>
<td>1515 - 1600</td>
<td>Section D - Finger to Nose:</td>
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<td>Practice Sessions - All instructors serve as coaches to the participants.</td>
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<td>1600 - 1620</td>
<td>Session X - Polydrug</td>
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<td>1620 - 1645</td>
<td>Session XI - Assessment Procedures</td>
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<td>1645 - 1700</td>
<td>Session XII - Conclusion (Written Exam)</td>
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<td>Entire Session</td>
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Session I

INTRODUCTION AND OVERVIEW

Objectives

Upon successfully completing this session, participants will be better able to

1. Understand the goal of the DITEP training course.
2. Recognize drugs that impair and make referrals to the appropriate sources.
3. Understand how DITEP can assist in identifying drug-impaired students.

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<td>C. Goal of the Training</td>
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<td>D. What is a Drug?</td>
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<td>E. Training Objectives</td>
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<td>F. Standardized and Systematic Procedures</td>
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<td>G. Overview of the Participant Manual</td>
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<td>H. Administrative Procedures</td>
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<tr>
<td>I. Test Your Knowledge (Pre-Test)</td>
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</table>

DITEP – Day 1
- Session I: Introduction and Overview
- Session II: Drugs in Society
- Session III: Overview of Alcohol
- Session IV: Drug Identification, Categories, and Their Observable Effects
- Session V: Policies, Procedures, and Contacting the Parent(s)
- Session VI: References
### A. Welcoming Remarks

Welcome to the Drug Impairment Training for Education Professionals (DITEP) training.

### B. Introductions

- Introduction of representatives of host school and other dignitaries.
- Instructor introductions.
- Participant introductions.

**Note:** Have participants introduce themselves with name, title, and school. If the class is too large for introductions, ask the participants to identify whether they are nurses, administrators, teachers, or others.

### C. Goal of the Training

- To enable education professionals to identify chemically impaired individuals and types of drugs for the purpose of ensuring a safe learning environment.

- A secondary goal of this training is to assist in preventing an impaired student from driving to and from the school campus.
**Note:** Stress that this training is not intended to qualify participants to be drug recognition experts (DREs) but is intended to aid in the evaluation and documentation of drug impairment in an academic environment.

**Note:** The information and procedures provided are for administrative purposes and not designed as an enforcement tool. Participants will be doing a lot less than a DRE would do in an enforcement setting.

**D. What is a Drug?**

The definition used in this training is:

Any substance that alters perception or behavior, reducing that individual’s ability to function appropriately in the academic environment.

All terminology and information in this training is based on medical and scientific facts and research.

The signs, symptoms, and impairment indicators to be presented and discussed have been researched and validated in both laboratory and field studies.
By participating in this training, participants will be better able to recognize drug impaired individuals and to make referrals utilizing the appropriate resources.

**E. Training Objectives**

The objectives of this training include:

- Understand the goals of DITEP training.
- Understand how DITEP can assist in identifying drug-impaired students.
- Properly recognize and describe drug impairment indicators.
- Understand the involvement of drugs in schools and society.
- Discuss the seven drug categories and their outward signs and indicators of impairment.
- Identify the key factors to be considered when discussing substance abuse with a parent.

Properly interpret and document the results of your observations.
F. **Standardized and Systematic Procedures**

It is important to remember that the DITEP process of identifying suspected impaired individuals is an educationally oriented STANDARDIZED and SYSTEMATIC approach.

This training will aide in identifying those who may be impaired by a drug or drugs to 1) improve the learning environment, 2) provide an early intervention and diversion, and 3) assess the need for medical assistance.

**Note:** Emphasize that the process can be discontinued at any time if a medical emergency is identified or suspected.

The conclusion of impairment must be based on the TOTALITY of information gathered through the systematic procedure and should not be based on any one element alone. All assessments should be done SYSTEMATICALLY and COMPLETELY in every instance except for medical emergencies.

G. **Overview of the Participant Manual**

- The Participant Manual is the basic reference document for this training.
- The Participant Manual includes a set of class note pages for every session.

**Note:** Go through and explain the Participant Manual to the participants. Stress the importance of taking notes and asking questions during the training.

**Note:** If Continuing Education Unit (CEU) credits are available, explain the procedure and provide forms.

**Note:** Remind participants that at the completion of the training there will be a final knowledge exam. Review with the class the reason necessary for the post-test.
H. Test Your Knowledge (Pre-Test)

At the completion of the training, there may be a final knowledge exam. It is provided to help in retaining the information and if CEU’s may be required.

Note: Use the following PowerPoint slides to conduct a group Test Your Knowledge exam (Pre-Test). The questions and answers are selectively displayed. Solicit answers from participants and encourage discussion.

---

True or False?
1. Marijuana is one of the most frequently abused drugs in schools today?
   - TRUE

2. People under the influence of methamphetamine will exhibit constricted pupils?
   - FALSE

3. Synesthesia is an indicator of hallucinogen drug use?
   - TRUE

4. "DXM" is a street name for dextromethorphan?
   - TRUE

5. U.S. citizens consume 40% of the world’s drugs (heroin, etc.)?
   - FALSE

6. An addicted heroin user will usually inject heroin 4-6 times each day?
   - TRUE

7. The effects of drugs on the user are independent of the user's personality, the environment, or how the drug was introduced?
   - FALSE

8. Cannabis causes an increased pulse rate?
   - TRUE

9. If a person's blood alcohol level is 0.08%, it will take approximately 2 hours of non-drinking to eliminate all alcohol and achieve a 0.00% blood alcohol level?
   - FALSE

10. Alcohol lowers inhibitions, therefore it is best classified as a stimulant?
    - FALSE

11. Most people abuse only one type of drug (their drug of choice) while usually not abusing other types of drugs?
    - FALSE

12. A person impaired by Xanax will appear similar to one intoxicated by alcohol?
    - TRUE

---

Conclusion of Session 1

Note: Ensure the participants understand the training objectives and the activities that will take place for the remainder of the training. Address any questions from Session 1.
Session II

DRUGS IN SOCIETY

Objectives

Upon successfully completing this session, participants will be better able to

1. Better understand drug trends and usage.
2. Understand why and how the DITEP training was developed.

<table>
<thead>
<tr>
<th>Content Segments:</th>
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<td>B. State and Local Drug Use</td>
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<td>C. Drugs and the Internet</td>
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<td>D. Development of the DITEP Training Program</td>
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<td>E. National Drug Statistics</td>
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<tr>
<td>H. Development of the DITEP Training Program</td>
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A. National Statistics

**Note:** Current annual drug data can be obtained as [www.monitoringthefuture.org](http://www.monitoringthefuture.org).

According to the National Survey on Drug Use and Health (NSDUH), in 2021 an estimated 61.2 million Americans aged 12 and older reported using illicit drugs in the past year.

The most used illicit drug was marijuana, with 52.5 million users.

The United States holds approximately 5% of the world’s population but consumes approximately 40% of the world’s prescription drugs.

Adolescent use of non-medical drugs indicates a growing number in the use of psychotherapeutics and pain relievers.

Three classes of the most frequently prescription drugs abused and misused are 1) Opioids (narcotic analgesics) that include drugs such as oxycodone, hydrocodone, and morphine; 2) Central Nervous System (CNS) depressants, which include Xanax, Ambien, Valium, and many benzodiazepines, and 3) CNS stimulants that include amphetamines and Adderall.

**Note:** Point out that Adderall has become a popular drug used by students in the academic setting as a “cognitive enhancer.”
According to the Substance Abuse and Mental Health Services Administration (SAMHSA) 2021 “National Survey on Drug Use and Health,” there were an estimated 2.5 million current abusers of prescription narcotic analgesics and over a half million heroin users in 2020. However, these numbers tend to vary region by region and state by state.

The same publication reported that there are approximately 5.2 million current (within the last month) users of cocaine aged 12 and older in the U.S.

Additionally, 5.1 million persons reported non-medical use of prescription stimulants, and 2.5 million reported using methamphetamine.

Additionally, in 2020, an estimated 7.1 million people reported using hallucinogens within the past year. The two most abused were LSD and Ecstasy.

**Note:** Remind the participants that these drugs and others discussed during this introduction will be covered in more depth later in this training.

According to the SAMHSA report and other sources, apart from alcohol, marijuana is the most abused drug in the United States. It is estimated that there were approximately 32.8 million Americans who reported marijuana use in the past month (2020). These numbers continue to vary as more states legalize or approve recreational marijuana.

**Note:** Ask “Apart from alcohol, what drug is the most abused drug in the U.S.?”
According to the 2022 Monitoring the Future study, the proportion of students reporting they have been drunk in the past 30-days remained steady. However, the long-term trend of American teens reporting they have been drunk in the past month has continued to decline. Since 1991 the rate among students in all three grades combined is down 60% proportionally from 19% in 1991 to 8% in 2022, and down 43% over the past decade down from 14% in 2013.

In 2022, nearly two percent of 8th graders reported being drunk in the past month, down 57% over the past 10 years. About one in twenty 10th graders (6%) say they have been drunk in the past 30 days. Seventeen percent of 12th graders report they have been drunk in the past month, declining 35% from 26% in 2013. 
(Source: NIDA National Survey Results on Drug Use, 2022 Monitoring the Future)

Causes for Teen Deaths

When discussing drug and substance abuse, we cannot overlook the issues of drug overdose and teenage deaths, especially involving the operation of a motor vehicle.

Note: Point out that in addition to this training equipping the participants in the dangers of drug use and impairment in the academic environment, it is also extremely important that this training help in deterring impaired driving on our roadways.

Motor vehicle crashes remains the number one cause for teenager deaths in the U.S. Every day, six teenagers in the 16 – 19-year-old age group die from motor vehicle crashes. Per mile driven, teenagers are nearly three-times more likely than drivers over the age of 20 to be a traffic fatality. 
(Source: Centers for Disease Control and Prevention)

Causes of Death for Teens

✅ #1 - Motor vehicle crashes for 16 - 19 year-olds
✅ Every day, six teens in the 16-19 year-old age group die from motor vehicle crashes
✅ Per mile driven, teens are nearly 3 times more likely than drivers over age 20 to be in a fatal crash

(Source: Centers for Disease Control and Prevention)
## B. State and Local Drug Use

**Note:** This section of the training should be used as an opportunity to discuss and highlight local, state, or regional drug trends and drugs of abuse, especially within the younger age groups.

Many drugs seem to come and go with their use, abuse, and popularity. Examples include such drugs as LSD, PCP, and others. Many times, this can be due to availability of the drugs, or newly reported dangers surrounding the drugs.

Another reason is referred to as “Generational Forgetting,” which is a term for when drugs make a comeback. This is often because young people’s knowledge of the drugs adverse consequences faded as generational replacement of the drugs took place.

“One generation may have learned the hard way about the dangers of a specific drug, the next generation may have to learn the same lesson all over again.” (Source: Monitoring the Future, 2019)

**Note:** Ask “What are some examples of drugs that may have been popular years ago, then faded in popularity, and are now once again popular in abuse, and how can this be dangerous today?

Because substance use trends shift, substance-specific health campaigns need to adapt to historical circumstances. In addition to the problems associated with population-level memory lapses, new drugs emerge, inspiring new studies, media campaigns, and policy responses.

**Note:** For the next section of training, instructors may want to use the internet to demonstrate from specific websites where information on drugs of abuse can be accessed.
C. Drugs and the Internet

Drugs are easily accessible through numerous social media platforms. The Internet has marked a revolution in the supply of illegal drugs, while at the same time, new types of illegal and semi-legal drugs increasingly are becoming available.

Some teens are buying and selling drugs online is via their social media platforms with peers. These platforms provide a way for users to connect with each other and exchange messages, making it easier to find and buy drugs. This can be as easy as signing into a site and searching “buy cocaine”, “buy weed”, and “buy shrooms” and numerous sites may emerge.

Encrypted messaging apps are also commonly used to buy and sell drugs within peer groups, or from a dealer who is commonly referred to as a “plug” online. These apps provide end-to-end encryption, making it more difficult for law enforcement, educators, and parents to intercept and read the messages.

Popular social media drugs include Kratom, GHB, and various club drugs like methylenedioxymethamphetamine (Ecstasy).

Many times, emojis are used to inform potential buyers about the products. The fire emoji can mean the drug is quality and the rocket emoji indicates a high potency. And the dollar signs mean that the substance is for sale. Other emojis used to describe drugs include the smoke, leaf, or the “okay” hand symbol emojis.

Purchasing drugs online is dangerous for both the buyer and seller. Even so, the internet and social media are popularly used for drug distribution.
D. Development of the DITEP Training Program

President Clinton’s Memo

In 1996, President Clinton sent a memo to the Secretary of Transportation pledging support to the development of programs dealing with the drug-impaired teen driver. This resulted in some states developing training programs to address this problem, which included educational and prevention programs such as DITEP.

Concept for DITEP Training

The concept of the training is to provide school administrators, teachers, nurses, and school resource officers (SRO’s) with a standardized and systematic approach to recognizing and evaluating individuals in the academic environment who may be abusing and/or impaired by drugs.

In order to provide early intervention, the states of Arizona, Kansas and New York developed training specifically for school personnel. The International Association of Chiefs of Police (IACP) recognized the need for a national training program and they, together with these three states, developed the DITEP training program.

Development of the Training

The basis for this training is the Standardized Field Sobriety Testing (SFST) and the Drug Evaluation and Classification (DEC) Program.

Note: If participant interest in the DEC Program is apparent, instructor can expound and give more details reference to the program.

A battery of standardized field sobriety tests was developed and validated for the investigation of alcohol impaired driving.
The DEC Program, also commonly referred to as the Drug Recognition Expert (DRE) program, was developed for law enforcement in response to a growing awareness that many DUI drivers were under the influence of drugs other than alcohol. All 50 states, Canada, and some other countries participate in the DEC Program, which is coordinated by the International Association of Chiefs of Police (IACP) and in cooperation with the National Highway Traffic Safety Administration.

The test battery for drug impairment was then validated in both the laboratory and the field and is one of the most effective drug driving enforcement programs in the world.

**Note:** Stress that it is also very important for the school to prevent students from driving to and from school while impaired by drugs.

**Conclusion of Session II**

**Note:** Solicit questions regarding this session from the participants.
## Session III

### OVERVIEW OF ALCOHOL

**Objectives**

Upon successfully completing this session, participants will be better able to

1. Name the three types of alcohol.
2. Describe a brief history of alcohol.
3. Identify common alcohol types.
4. Describe the physiologic process of absorption, distribution, and elimination of alcohol in the human body.

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<td>D. Elimination</td>
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<td>E. Dose/Response Relationships</td>
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![Session III Overview of Alcohol](image-url)
Alcohol abuse and misuse remains a major concern in America and throughout the world. In 2021, the National Survey on Drug Use and Health (NSDUH) reported there were an estimated 138.5 million alcohol users, which is slightly less than half of all Americans. And, approximately 17.7 million people described themselves as heavy drinkers.

Alcohol is a Central Nervous System (CNS) Depressant drug, despite an initial feeling of energy it may provide users. It is and continues to be the most abused drug in the United States.

In 2021, 3.2 million youth, ages 12 to 20, reported binge drinking at least once in the past month, according to the NSDUH. Some research data indicates that adolescent use of alcohol exceeds the use of tobacco and/or marijuana.

The drinking trends of the younger generation include mixed drinks, combinations of alcohol and energy drinks (alcoholic speedballs), ultrahigh-proof alcohols, jello-shots, and micro brewed beers. In addition, their ingestion of alcohol has taken on new variations including inhaling alcohol fumes using pressurized air pumps and vaporizers to turn their alcohol of choice into an inhalable, high-proof alcohol vapor.

With the expanding use of e-cigarettes and the evolving vaporizing techniques, “vaping” has become a common ingestion method for alcohol as well as other drugs.

Another used method of ingestion is an alcohol enema where the alcohol is ingested directly into the body. These methods have their dangers. Inhaling alcohol vapors or ingesting it in locations other than the mouth removes the digestive system process and quickly moves the alcohol into the bloodstream which is then pumped directly to the brain.
To understand the impact of alcohol, it is important to take a closer look at alcohol, and its effects on the body.

### A. Physiology of Alcohol

The word “Alcohol” refers to several distinct, but similar, closely related chemicals, whose molecules are made up of hydrogen, carbon, and oxygen.

Each of the alcohols is a drug within the scope of our definition.

### B. Types of Alcohol

We primarily focus our attention on Ethanol since it is the only one intended for human consumption.

Ethanol is the active ingredient in beer, wine, whiskey, and other alcoholic beverages.

Historically, it is abused by youth more often than other substances, including tobacco and marijuana. However, recent data indicates that alcohol consumption among teens is declining.

Ethanol is produced through a process called fermentation.

Years ago, natural fermentation occurred when sugar in the fruit or grain chemically reacted with yeast and produced alcohol. Today, most fermentation takes place under controlled conditions.

Distillation is the process used to produce a higher concentration of alcohol. Distillation occurs when a fermented beverage is heated to the point where ethanol begins to boil, and the ethanol vapor is collected and allowed to cool until it turns back into a liquid.
By repeating the process of heating the liquid, cooling, and collecting the vapors, higher concentrations of ethanol can be produced.

Alcoholic beverages produced by distillation are called “distilled spirits.” Distilled spirits include whiskey, vodka, gin, and rum.

Over the years standard-size servings of different alcoholic beverages have evolved.

- Beer is usually served in 12-ounce bottles or cans. Beer averages an ethanol concentration of about 5 percent, with some brands going over 12 percent. A can or bottle contains a bit less than one-half ounce of pure ethanol.

- Typically, a four-ounce glass of wine has an ethanol concentration of 12 percent. A glass of wine has just a bit less than one-half ounce of pure ethanol.

**Note:** Point out that typical bar/restaurant servings of wine are six to ten ounces.

Whiskey and other distilled spirits are dispensed in a “shot” glass. A shot usually contains one and one-quarter ounces of liquid.

**Note:** Point out the proof of a distilled spirit is equal to twice the ethanol concentration. (Example: 80 proof whiskey contains 40% ethanol)

For all practical purposes, standard-size servings of beer, wine and whiskey all pack the same “punch.”
### C. Physiological Process

We primarily focus our attention on Ethanol since it is the only one intended for human consumption.

- It doesn’t impair until it gets into the brain.
- It can’t get into the brain until it gets into the blood.
- It can’t get into the blood until it gets into the body.
- The most common method of ingesting alcohol is by drinking.

**Note:** Point out alcohol, in addition to drinking it, can be injected, inhaled (fumes) or inserted into the body in a variety of ways.

### D. Absorption

**Note:** Point out, this is a brief overview of the physiology of alcohol.

Alcohol, unlike food, does not need to be digested prior to moving from the stomach into the small intestine.

Stomach acids and enzymes start to break down the food, preparing it to pass to the lower portion of the gastrointestinal track.

When alcohol is consumed with food, it will be trapped in the stomach and the stomach acids and enzymes will begin to break it down.

If alcohol is consumed on an empty stomach, it will pass quickly through the base of the stomach, into the small intestine and will move quickly into the bloodstream.

**Note:** Explain the process of absorption. Explain the pylorus and its function.
E. Distribution

Once alcohol gets into the blood, the blood carries it to various tissues and organs in the body.

Water is attractive to alcohol. The blood will deposit the alcohol in all the parts of the body where water is found.

Parts of the body that have a lot of water will collect much of the alcohol.

Parts of the body that have little water will receive smaller amounts of alcohol.

Pose question: Ask about the body parts that contain lots of water and solicit responses from the participants, then reveal bullet points.

Parts of the body that have lots of water include:

- Brain
- Liver
- Muscle tissue
- Kidneys

Pose question: Ask about the body parts that contain less amounts of water and solicit responses from the participants, then reveal bullet points.

Parts of the body that have less amounts of water include:

- Bones
- Fatty tissue

Muscle tissue will receive a relatively high proportion of the alcohol that a person consumes.
Fatty tissue will receive very little of the alcohol consumed.

An interesting and significant difference between men and women is that pound for pound, the average male has more water in his body than the average female.

Note: Point out the average male is 68% water. The average female is 55% water. Pose the question as to why this difference exists.

- The female body has more fatty tissue than the male body.
- Pound-for-pound, the average female has more fat and less muscle than the average male.
- Fatty tissue contains very little water.
- The average female has fewer places in her body to deposit the alcohol consumed.

Note: Point out for clarification, the female’s extra fatty tissue serves as a “shock absorber” and thermal insulator to protect a baby in the womb.

F. Elimination

The woman’s blood alcohol concentration (BAC) will be higher than the man’s because she has less water in which to distribute the alcohol.

Pose question: If a man and woman weigh exactly the same and drink exactly the same amount of alcohol under the exact same conditions. Who will obtain a higher BAC?

As soon as alcohol gets into the body, the body begins working to eliminate it.

- Some alcohol is expelled directly from the body, i.e., in the breath, urine, sweat and tears, etc.
- The majority of the alcohol consumed is metabolized by the liver.
**Note:** Point out for clarification, only 2-10% of the alcohol consumed is directly expelled through breath, sweat, tears, urine, etc.

<table>
<thead>
<tr>
<th>The metabolism of alcohol consists of a slow controlled burning of the alcohol.</th>
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**Note:** The liver contains an enzyme called alcohol dehydrogenase which aids in the metabolism of alcohol.

<table>
<thead>
<tr>
<th>The speed that the liver metabolizes alcohol varies from person to person and may periodically change for any person.</th>
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</table>

<table>
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<tr>
<th>The average rate of metabolism is 0.015% per hour.</th>
</tr>
</thead>
</table>

**Pose question:** A person reaches a peak BAC of 0.15%. How long will it take for his or her body to eliminate all of the alcohol?

**Answer:** Ten hours

\[
0.15\% - (x \text{ hours}) (0.015\%)
\]

\[
X = 10
\]

For the average male, a BAC of 0.015% is equal to about two-thirds the alcohol content of a “standard” drink.

For the average female, a BAC of 0.015% is equal to approximately one-half the alcohol content of a “standard” drink.

**Note:** The average male can burn off about two-thirds of a drink in an hour, while the average female can only burn off about one-half of a drink per hour.

**Note:** The average male can burn off about two-thirds of a drink in an hour, while the average female can only burn off about one-half of a drink per hour.

There is nothing we can do to speed up the rate of metabolism.

- Drinking coffee doesn’t help.
- A cold shower doesn’t help.
- Exercise doesn’t help.
- “Magic” mystery potions don’t help.
### G. Dose/Response Relationships

There is no simple answer to the relationship of dose response to alcohol.

- ANY amount of alcohol consumption will affect a person.
- The amount needed to be consumed to get impaired varies as previously described. It can vary from person to person.

Reaching these blood alcohol content depends upon numerous factors, including:

- Man or woman
- Size
- Stomach content
- Time consumed
- Amount consumed
- Health conditions
- Type of alcohol consumed

**Pose question:** How much alcohol does it take to get “impaired?”

In one respect, it doesn’t take very much alcohol to impair someone. A couple beers can do it.

**Note:** Example of 175-pound man drinks 2 beers or 2 shots in quick succession on an empty stomach, his BAC will climb to slightly above 0.04%. Two more beers will boost him above 0.08%. One more will push him over 0.10%

**Note:** If internet is available and time allows, consider accessing showing the “How Does Alcohol Make You Drunk” video using the website link in the slide. The video is approximately 5 minutes and 22 seconds in length.
**Conclusion of Session III**

**Note:** Solicit questions regarding information covered in Session III.
Session IV

DRUG IDENTIFICATION, CATEGORIES, AND THEIR OBSERVABLE EFFECTS

Objectives

Upon successfully completing this session, participants will be better able to

1. Define the word “drug” and other terms associated with drug impairment.
2. Identify the seven categories of drugs used in this training.
3. Recognize and describe general indicators of impairment of the seven drug categories and drug combinations.
4. Become familiar with common drugs from the seven drug categories.
5. Be familiar with conditions that may mimic indicators of drug impairment.
6. Be familiar with overdose symptoms of the drug categories.
7. Be familiar with some medical conditions that may mimic drug impairment.

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<tr>
<th>Content Segments:</th>
<th>Learning Activities:</th>
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</thead>
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<td>○ Instructor Led Presentations</td>
</tr>
<tr>
<td>B. Seven Drug Categories</td>
<td></td>
</tr>
<tr>
<td>C. Drug Combinations</td>
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</tbody>
</table>
Throughout history, some people have chosen to alter their perception of reality with psychoactive substances. Psychoactive substances are used to alter states of consciousness, reduce pain, deal with harsh surroundings, alter a mood, medicate a mental illness, or enhance the senses.

The popularity of new psychoactive drugs continues to grow due to new technologies, the Internet, and the proliferation of street chemists and their customers. New drugs and psychoactive substances are constantly being developed or reformulated. Many are specifically designed to stay one-step ahead of detection, and state and federal laws.

Psychoactive drugs include natural, semisynthetic, and synthetic substances that directly affect the neurochemistry and the anatomy of the Central Nervous System (CNS), causing mental, emotional, and physical changes and reactions.

A. Definition of “Drug”

Pose question: Ask the following to the participants:

- Are all drugs medicines?
- Are all medicines drugs?
- Are all drugs narcotics?
- Are all drugs habit-forming substances?
- What substances might be considered “drugs” that are not commonly thought of as drugs?

The definition of drug as used in this training is:

“Any substance that alters perception or behavior, reducing that individual’s ability to function appropriately in the academic environment.”
Note: This definition may not include substances physicians, chemists, etc. consider to be drugs, e.g., antibiotics, Novocain, vitamins, etc. For our purposes, it does include substances not normally thought of as “drugs,” such as glue, aerosols, etc.

B. Seven Drug Categories

Psychoactive drugs have chemical names, trade names, and street names. For this training, psychoactive drugs (or substances) are classified by their overall effects.

Within this training, and other impaired driving training courses (Standardized Field Sobriety Testing, Advanced Roadside Impaired Driving Enforcement and Drug Recognition Expert), there are seven drug categories.

Each category consists of many substances that can impair a person’s mental and physical abilities. The categories differ from one another in terms of how they impair ability and the type of impairment they produce.

Because the categories produce different types of impairment, they generate different signs, symptoms, and indicators.

With training and practice, you will be able to recognize signs, symptoms, and general indicators of drug influence and determine what category is likely causing the observed impairment.

Note: Point out why drugs are placed into their categories. Even though drugs within each category may be very different in their makeup, the observable and measurable signs, symptoms, and general indicators produced are similar.
Central Nervous System (CNS) Depressants

CNS Depressants slow down the processes of the brain and many other functions that the brain controls. In year’s past, they were often referred to as “Downers.”

At first, and immediately recognizable, are the effects to the voluntary bodily functions, such as speech, coordination, and mobility.

As the dosage increases, impairment in the bodies’ automatic nervous system, such as heartbeat, body temperature, and breathing will be observable.

The most familiar and abused CNS Depressant in the U.S. is alcohol.

Many CNS Depressants are legally prescribed for depression, anxiety, phobias, and other psychotic disorders.

Some popular CNS Depressants other than alcohol include:

- Barbiturates (derivative of barbituric acids) such as Secobarbital and Phenobarbital
- Sedative-Hypnotics, such as Alprazolam (Xanax), Clonazepam (Klonopin), Diazepam (Valium), Lorazepam (Ativan), and Carisoprodol (Soma)

Note: If internet is available, consider showing the “Your Brain on Xanax” YouTube video which can be accessed using the link in the PowerPoint slide. The video is approximately 2 minutes and 30 seconds in length. Ensure the video is in “Theater Mode” for viewing.
- Antidepressants, such as Fluoxetine (Prozac) and Trazadone (Desyrel)
- Antipsychotics, such as Chlorpromazine (Thorazine) and Olanzapine (Zyprexa)
- Other examples of CNS depressants such as Quaaludes, Gamma-Hydroxybutyrate (GHB), Diphenhydramine (Benadryl) and Kava

**Note:** Point out there are hundreds of CNS depressant drugs and therefore it is difficult to mention all of them in this training.

**Note:** The following information about GHB and Kava may not be relevant to the local area. (Instructors should reference local drug trends whenever practical)

GHB gained popularity with the party/rave scene. It is used mainly for its intoxicating effects. It is readily available, and recipes are available on the Internet making it easy to make and abuse. The effects of GHB depend on the user and the manufacturer.

**Note:** Illegally made ingredients may not always contain the same concentrations. Doses may not always be the same. One dose per bottle-capful, two doses per capful, etc. A personal dose range is difficult to find, an extra quarter gram can be the difference between euphoria and vomiting.

Kava

Kava is a mild depressant made from the roots of the Piper Methysticin plant, which is found in the South Pacific and South America. Typically, the roots are chewed or soaked into a soapy liquid and swallowed that produces a drunken state, like that of alcohol, when used in large quantities. Kava is sold as an herbal supplement to relieve anxiety, stress, and insomnia.

In general, people under the influence of CNS Depressants look and act much like people under the influence of alcohol.
### Expected Results of Observations/Indicators of CNS Depressant Impairment:

<table>
<thead>
<tr>
<th>Psychophysical Indicators:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Divided attention impairment</td>
</tr>
<tr>
<td>Poor coordination and balance</td>
</tr>
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</table>

**Note:** Point out divided attention tests are methods of assessing the person’s ability to divide his/her attention between simultaneous mental and physical tasks. These tests are simple to administer, and more importantly, not difficult to perform if the person is not impaired.

### Eye Indicators:

- Horizontal Gaze Nystagmus (HGN), which is the eyes’ inability to fixate or gaze on a moving stimulus as they move side to side, will usually be present.
- Vertical nystagmus, which is elevating the eyes upward will be present with high doses for that individual.

**Note:** Point out Horizontal Gaze Nystagmus is the eyes inability to fixate (gaze) as they are moved towards the side (horizontally). Nystagmus is the involuntary jerking of the eyes and is a naturally occurring phenomenon caused by the ingestion of certain categories of drugs. (If video of HGN is available, this may be used to demonstrate HGN and VGN)

- Pupil size will usually be normal.

**Note:** The size of a person’s pupils changes naturally in response to changing light conditions. It is not necessary that a precise estimate of pupil size be obtained. It is enough to estimate if the pupils are of an equal size and whether they look noticeably small, about normal, or noticeably large.

### General Indicators of CNS Depressant Impairment:

- Drowsy acting
- Thick, slurred speech
- Uncoordinated, fumbling fingers
- Flaccid muscle tone
- Sluggish acting
- Droopy eyelids
- Bloodshot, watery eyes

![General Impairment Indicators](image-url)
• Slowed reflexes
• Poor balance and coordination
• Drunk-like behavior

**Note:** Point out each of the indicators discussed are contained in the DITEP Drug Matrix located in the Participant Manual at the end of this session. Instructors may want to refer the participants to the matrix when discussing the impairment indicators.

**Other Conditions That May Mimic CNS Depressant Indicators:**

- Extreme fatigue
- Head injury
- Hypotension (abnormally low blood pressure)
- Severe depression
- Diabetic reaction
- Inner ear disorders

**Possible CNS Depressant Overdose Symptoms:**

- Shallow breathing
- Clammy skin
- Rapid/weak pulse
- Coma

**Note:** Point out if overdose symptoms are detected, it should be treated as a medical emergency.

**Methods of CNS Depressant Ingestion:**

- Oral
- Injected
CNS Depressant Duration of Effects:

Depending on the type of depressant, the effects can last a few minutes to approximately 12 - 14 hours.

Note: Solicit questions regarding CNS Depressants.

Central Nervous System (CNS) Stimulants

CNS Stimulants accelerate (speed up) the heart and many other body processes. For that reason, they have also been referred to as “Uppers.”

Although there is a great difference in strength, all stimulants increase the chemical and electrical activity in the CNS. The “speeding up” also produces an inability to concentrate or think clearly.

Stimulants boost energy, raise the heart rate and blood pressure, increase respiration, and reduce appetite.

Legal stimulants can be prescribed for attention-deficit hyperactivity disorder (ADHD), weight loss, and narcolepsy.

Some commonly abused CNS Stimulants include:
- Cocaine (Crack) – Naturally derived from the leaves of the coca plant. “Crack” is the street name given to Cocaine processed from Cocaine Hydrochloride.
- Amphetamines – Includes many prescription drugs such as Adderall, Dexedrine, and Ritalin
- Methamphetamine – Illegally produced drug, with the exception of Desoxyn, which is a prescription drug used to treat narcolepsy and attention deficient disorder (ADD) and attention deficit hyperactivity disorder (ADHD). The majority of street methamphetamine is produced in clandestine laboratories. Illicit methamphetamine is also known as methedrine or methamphetamine hydrochloride. Its more common street names are speed, crank, ice, crystal, meth, and water.
- Herbal, Over-the-Counter (OTC), Caffeine, Ephedrine, Pseudoephedrine, and various energy drinks

### Energy Drink Phenomenon

In the 1980’s the marketing and use of energy drinks changed dramatically with the advent of products such as Red Bull ®.

Many OTC energy drinks now contain well over 80 mg of caffeine, some as high as 100 mg. In addition to high levels of caffeine, many energy drinks contain taurine, ginseng, guarana, glucose, and other caffeine-like chemicals.

The abuse of energy drinks has been implicated in numerous hospital admissions and impaired driving cases. In large quantities, the effects can mirror the effects of other CNS stimulants.

**Note:** Point out there are many types and brands of energy drinks, and some have dangerously high levels of caffeine.
Over the Counter (OTC) Stimulants

Legal CNS stimulants are often used to boost performance, especially among athletes and students and are available over the counter. Besides high-caffeine energy drinks, there are many abused OTC stimulants which include Ephedra (Ma Huang) and Ephedrine. Ma Huang is a Chinese herb that comes from the ephedra bush. The active ingredients are ephedrine (a bronchodilator) and pseudoephedrine (a nasal decongestant). Ephedra and ephedrine are commonly used in many legal over-the-counter medications and diet medications.

Adderall

Adderall is a prescription medication that contains two drugs: amphetamine and dextroamphetamine. It is often prescribed to treat attention deficit hyperactivity disorder (ADHD). Various studies of Adderall and Adderall XR show that the drugs improve attention and focus and reduce impulsive behaviors. Thus, it is often referred to as a “cognitive enhancer” drug. It can also be effective for increasing daytime wakefulness in people with narcolepsy.

Prolonged use of the drug can in some cases lead to inappropriate usage, resulting in severe side effects. (With misuse, a drug is taken in a way other than how it’s prescribed). Misuse of Adderall is a growing epidemic, especially on college campuses. Many college students use Adderall to help them study. But some research suggests that Adderall doesn’t improve thinking and might even worsen memory.
**Note:** If internet is available, consider showing the “Your Brain on Adderall” YouTube video which is approximately 3 minutes and 20 seconds in length. The video can be accessed using the link in the PowerPoint slide. Ensure the video is on “Theater Mode” for viewing.

Expected Results of Observations/Indicators of CNS Stimulant Impairment:

**Psychophysical Indicators:**
- Divided attention impairment.
- Rapid and jerky movements.
- Hyperactive, talkative, restless, and nervous acting.

**Eye Indicators:**
- Nystagmus (HGN) will typically not be present.
- Pupils will usually be noticeably larger in size (dilated).

**Note:** Point out generally, if the pupil covers more than approximately 50% of the iris, it is considered dilated.

**General Indicators of CNS Stimulant Impairment:**
- Restlessness
- Anxiety
- Excited
- Runny nose
- Paranoia
- Dry mouth
- Loss of appetite
- Dilated pupils
- Body tremors
- Bruxism (grinding of teeth)
- Exaggerated reflexes
- Talkative
- Euphoria
- Irritability
- Loss of weight

**Other Conditions That May Mimic CNS Stimulants Indicators:**

- Hyperactivity
- Nervousness
- Stress
- Fear
- Hypertension

**Possible CNS Stimulant Overdose Symptoms:**

- Confusion
- Feelings of pleasure to panic
- Convulsions
- Fainting
- Aggressiveness
- Dramatic increase in heart rate
- Hallucinations
- Coma

**Note:** Point out CNS Stimulant related death can occur from sudden respiratory failure, or heart arrhythmia, leading to cardiac arrest.

**Typical Methods of Ingestion:**

- Oral
- Smoking
- Snorting
- Injecting

**Note:** Point out that smoking produces an instant high.
### Duration of Effects:

- **Cocaine (Powder - Snorted):**
  - Onset - immediate
  - Duration – 45 to 90 minutes

- **Cocaine (Crack – Smoked):**
  - Onset – immediate
  - Duration – 5 to 10 minutes

- **Amphetamine (Oral, pill form):**
  - Onset - 30 to 40 seconds
  - Duration - 4 to 8 hours

- **Methamphetamine (Crank or Speed – Snorted, Injected or Oral):**
  - Onset – 30 to 40 seconds
  - Duration – Up to 12 hours

### Possible CNS Stimulant Overdose Symptoms:

- Dramatic increase in heart rate
- Hallucinations
- Psychosis

**Note:** Methamphetamine psychosis is an overdose reaction to methamphetamine.

**Note:** Solicit questions regarding CNS Stimulant.
Hallucinogens

Hallucinogens are drugs that can cause hallucinations and typically cause the user to perceive things differently from what they actually are.

Drugs and other substances in this category have also been referred to as “Psychedelics.”

Hallucinogenic drugs usually produce what are called pseudo-hallucinations. That is, the user is aware that what he/she sees, hears, or smells isn’t real, but is an effect caused by the drug.

Hallucinogens can cause a disruption of the visual and auditory centers and a crossover or mixing of the senses. This is called synesthesia, which is the transposition of sensory modes or the transposition of senses. Some examples include seeing sounds, hearing colors.

Some hallucinogenic drugs occur naturally, others are synthetically produced.

Synthetic examples:

- LSD (Lysergic acid diethylamide) - Manufactured from lysergic acid which occurs naturally in the ergot fungus that grows on wheat and rye.

**Note:** If internet is available, consider showing the “Your Brain on MDMA” YouTube video which can be accessed by using the link in the PowerPoint slide. The video is approximately 2 minutes and 35 seconds in length. Ensure the video is in “Theater Mode” for viewing.
- **MDMA (3, 4-Methylenedioxymethamphetamine)** - A derivative of methamphetamine with both stimulant and psychedelic effects. It alters mood and perception (awareness of surrounding objects and conditions). It is chemically similar to both stimulants and hallucinogens, producing feelings of increased energy, pleasure, emotional warmth, and distorted sensory and time perception. Street names include Ecstasy, Molly, X, XTC, and the Love Drug.

- **Designer Psychedelics** – Group of synthetic drugs similar to mescaline. Used for mental exploration and later for recreation. Includes numerous substances with chemical names, such as, 2C-1, 2C-B, and 2C-1NBOme. Street names include Smiles, C-bomb, N-bomb, Benzofury, and Nexus.

**Note:** Point out there are many designer psychedelics and new substances are being illegally marketed on a regular basis.
Natural examples:

- **Salvia Divinorum** – Has unique psychic effects likened to a combination of various hallucinogenic drugs. Often compared to the effects of LSD. Street names include Sage, Magic mint, and Sally D.

- **Peyote** – Contains mescaline, the active ingredient of the peyote cactus.

- **Psilocybin (Mushrooms)** – Also referred to as “magic mushrooms” or “shrooms” whose active ingredients are psilocybin and psilocin. Can be in mushroom form or can also be in a capsule form.

- **Morning Glory Seeds** – LSD-like substances about one-tenth as potent as LSD. Street names include heavenly blue, flying saucers, and pearly gates.

**Note:** Point out that some of hallucinogens discussed in this training have been or are being considered for legalization in some states, therefore making them more accessible for use and potential abuse.

People under the influence of hallucinogens are usually extremely impaired and may exhibit bizarre behavior.

Some hallucinogen users experience mental flashbacks or sensations of a trip they once had while under the influence of LSD or another hallucinogen. The flashbacks, which can be triggered by stress, the use of another psychoactive drug, or a sensory stimulus (light, smell, or odor), re-create the original experience. The flashback can also cause anxiety and panic because it is unexpected, and the user seems to have little control over its recurrence.

**Note:** Point out a flashback is a vivid memory. You will see physiological indicators (example: elevated pulse, blood pressure, etc.)
Expected Results of Observations/Indicators of Hallucinogen Impairment:

Psychophysical Indicators:
- Uncoordinated
- Severe divided attention impairment
- Poor perception of time and distance
- Poor balance

Eye Indicators:
- Nystagmus (HGN) will not be present
- Pupils will typically be large in size (dilated)

General Indicators of Hallucinogen Impairment:
- Dazed appearance
- Body tremors
- Perspiring
- Paranoia
- Disoriented
- Nausea
- Difficulty with speech
- Statements suggesting hallucinations
- Flashbacks
- Uncoordinated
- Memory loss
- Synesthesia

Other Conditions That May Mimic Hallucinogen Indicators:
- Mental illness
- High fever

Possible Hallucinogen Overdose Symptoms:
- The most common danger of an overdose of hallucinogen is an intense bad trip, which can result in severe and sometimes permanent psychosis.
Note: Point out accidental death or suicide may also result from an intense bad trip.

Methods of Ingestion:
- Oral
- Smoked
- Transdermal absorption
- Injected
- Snorted

Note: Point out LSD and some other hallucinogen drugs can be absorbed through the skin. Caution should be exercised when handling suspected drugs that can be absorbed through the skin.

Duration of Effects
- LSD
  - Onset: 30 - 60 minutes
  - Duration: 6 to 8 hours
- Peyote
  - Onset: 30 minutes – 1 hour
  - Duration: 10 to 12 hours
- Psilocybin Mushrooms
  - Onset: Within 30 minutes
  - Duration: Up to 5 hours
- MDMA
  - Onset: 30 minutes - 1 hour
  - Duration: 1 to 3 hours

Source: Drug Identification Bible, 2022 - 2023

Note: Solicit questions regarding Hallucinogens
Dissociative Anesthetics

Dissociative Anesthetics are a group of unique drugs that dissociate the users thought process and can cause disassociation or an “out-of-body” sensation. This category includes the following substances:

- **Phencyclidine (PCP)** – A illegal drug with a shortened title of the chemical name PhenylCyclohexylPiperidene. Originally developed for veterinary medicine use and not approved for human use due to its toxic and hallucinogenic effects. Has numerous street names including angel dust, peep, KJ, whack, and rocket fuel.

- **Ketamine** – A drug used in human and veterinary medical procedures that produces similar effects to PCP. It is considered an analog of PCP. It is sold under the trade names of Ketanest ®, Ketaset ®, and Ketalar ® with street names of Special K, Vitamin K, and Kit Kat.

**Note:** Point out an analog is a chemical “cousin” of the parent drug. It has a slightly different chemical structure but produces similar effects as the parent drug.

- **Dextromethorphan (DXM)** – A legally produced synthetic analog of codeine, commonly referred to as DXM. It is found in more than 120 over-the-counter cold medications. Typically, in extra-strength cough syrups, tablets, and gel capsules. DXM is either the primary ingredient or mixed in combination with other medications like antihistamines, analgesics, expectorants, and decongestants. When abused or used in high doses, it can produce effects similar to marijuana, ketamine, or PCP.
intoxication, including euphoria and visual and auditory hallucinations. It is often referred to as “purple drank.”

Dissociative Anesthetics share characteristics with three of the previously discussed drug categories:

- Like CNS Depressants, Dissociative Anesthetics will cause nystagmus (involuntary jerking of the eyes), slurred speech and slow responses.
- Dissociative Anesthetics elevate the vital signs and cause behavior much like CNS Stimulants.
- Dissociative Anesthetics can cause hallucinations much like Hallucinogens.

**Note:** Point out there are many street names for Dissociative Anesthetics and substances such as DXM and PCP have often been glamorized in music making some more appealing to younger people.

Like many other drugs, the drugs within the Dissociative Anesthetics drug category have numerous street names. Some include: Robo, Skittles, Triple C, Sizzurp, Angel Dust, Rocket Fuel, Special K, and Super K.

**Expected Results of Observations/Indicators of Dissociative Anesthetic Impairment:**

**Psychophysical Indicators:**
- Divided attention impairment

**Eye Indicators:**
- Horizontal gaze nystagmus (HGN) will be present.
- Vertical gaze nystagmus (VGN) will be present.
Pupils will typically be normal in size.

General Indicators of Impairment:

- Blank stare
- Loss of memory
- Confused
- Perspiring heavily
- Incomplete, slurred verbal responses
- Agitation
- Rigid muscle tone
- Non-responsive
- Slowed responses

Typical Dosing Plateaus Associated with DXM:

- 1st plateau: mild inebriation, 100 – 200 mg.
- 2nd plateau: similar to alcohol intoxication with mild hallucinations, 200 – 400 mg.
- 3rd plateau: an altered state of consciousness where the abuser’s senses, particularly vision, can become impaired, 400 – 600 mg.
- 4th plateau: mind and body dissociation or an out of body experience (similar to dose of Ketamine), 600 - 1500 mg.

Note: The sources regarding DXM include the NHTSA “Drugs and Human Performance Fact Sheets” and National Institute on Drug Abuse (NIDA).

Other Conditions That May Mimic Dissociative Anesthetic Impairment:

- Mental disorders
- Mental illness
Possible Overdose Symptoms:
- A deep coma, lasting for up to 12 hours
- Seizures and convulsions
- Respiratory depression
- Possible cardiac problems
- Bizarre, violent, and self-destructive behavior

Typical Methods of Ingestion:
- Smoked
- Snorted
- Oral
- Injected
- Transdermal absorption

**Note:** Point out marijuana cigarettes laced with PCP are popular and are commonly abused in various parts of the country.

Duration of Effects:
- **PCP**
  - Onset: 1 - 5 minutes
  - Duration: 4 - 6 hours
- **Ketamine**
  - Onset: 1 - 5 minutes
  - Duration: Up to 2 hours
- **Dextromethorphan (DXM)**
  - Onset: Rapidly absorbed
  - Duration: 3 - 6 hours

**Note:** Solicit questions regarding Dissociative Anesthetics.
**Narcotic Analgesics**

Narcotic Analgesics are a category of drugs refined from or are synthetic versions of the opium poppy’s active ingredients. This category includes many drugs primarily developed for the treatment of moderate to acute pain, diarrhea, coughing, and other conditions.

Drugs in this category are often referred to as “pain killers. They typically induce euphoria, alter moods, and produce sedation.

Most illicit users take opiate/opioid drugs to avoid emotional and physical pain, to experience euphoric effects, and to suppress withdrawal symptoms.

**Note:** Point out Narcotic Analgesic prescription drugs are one of the most often abused drugs. Males 18 to 25 are the most likely to abuse this category of drugs, followed by females aged 12 to 17.

People often develop a tolerance for narcotic analgesics rapidly.

“Tolerance” means the same dose of the drug will produce diminishing effects. Therefore, a narcotic analgesic user will need an increasing dose of the drug to achieve the same desired effect.

**Note:** Point out habitual users of certain drugs may develop tolerance to the drug. Thus, they may exhibit relatively little evidence of impairment. However, when impaired, tolerant users may exhibit clinical evidence, i.e., in the vital signs and the eye examinations.

Narcotic Analgesics all share three characteristics. They produce analgesia (pain relief), they produce withdrawal signs and symptoms, and they suppress withdrawal signs and symptoms. For our training purposes, there are two types of narcotic analgesics:

**Note:** Point out there are many narcotic analgesic drugs that are considered opiates and/or opioids and due to time limitations, only some of the most frequently abused drugs will be covered in this training.

### Opiates - drugs that either contain or are derived from opium and include:

- **Heroin (Diacetylmorphine)** – An opiate typically used as a recreational drug for its euphoric effects. Medically it is occasionally used to relieve pain and as a form of opioid replacement therapy alongside counseling (not in the U.S.).

- **Morphine (Infumorph®, Kadian®, Roxanol®, MS Contin®)** – Used to treat moderate to severe pain that lasts for more than a few days. It is available in a variety of prescription forms, including tablets, capsules, suppositories, oral solutions, skin patches, and injectable solutions.

- **Codeine** – A pain reliever and cough suppressant similar to morphine and hydrocodone. It typically causes sedation, drowsiness, and depresses breathing. It is frequently combined with acetaminophen (Tylenol) or aspirin for more effective pain relief.

- **Hydromorphone (Dilaudid®, Hydrostat®, Palladone®)** – A semisynthetic opioid. It is refined from morphine making it five to eight times more potent gram-for-gram than morphine.

- **Oxycodone (OxyContin®, Percodan®, Percocet®)** – A semisynthetic derivative of codeine used for the relief of moderate to severe pain. Its pain-relieving effects are much stronger than those of codeine but weaker than those of morphine. OxyContin has received
attention for his high abuse level. Street names include “oxy,” “o’cotton,” and “hillbilly heroin.”

Opioids

Drugs not derived from opium but produce similar or identical effects as opium alkaloids and derivates. Includes many synthetically produced drugs such as:

- **Fentanyl** – A highly potent opioid with a rapid onset and shorter duration of action. Fentanyl can be 80 to 100 times or more potent than morphine. Fentanyl can be prescribed and is available in patch form. As a street drug, fentanyl is found in counterfeit pills and in powders, either alone or in combination with other drugs such as opioids, cocaine, and/or fentanyl analogs. It is a drug implicated in many overdoses.

**Note:** If internet is available, show the video “Your Brain on Fentanyl” which can be accessed using the website link in the PowerPoint. The video is approximately 3 minutes and 45 seconds in length.

- **Methadone** - A synthetic narcotic analgesic available by prescription as oral solutions, tablets, dispersible tablets, or injectable solutions. It is prescribed for the relief of moderate to severe pain and is used in detoxification treatment of opioid dependence and maintenance in narcotic addiction. Compared to morphine, methadone has a much longer duration of action, suppressing opiate withdrawal symptoms and
remains effective for an extended period of time with repeated administration. Recreationally, methadone is abused for its sedative and analgesic effects.

- **Buprenorphine (Suboxone®, Buprenex®, Subutex®)** - A semisynthetic powerful opioid agonist at low doses and an opioid antagonist at high doses. Primarily prescribed for the treatment of opioid addiction, but may also be used to treat pain, and sometimes nausea, most often in transdermal patch form.

Other Narcotic Analgesics

- **Kratom (Mitragynine)** – Produced from the leaves of tropical trees native to Indonesia, Malaysia, Thailand, and other areas of Southeast Asia. At high doses, it delivers opioid-like effects, inhibits smooth muscle control, and reduces pain. At low doses, it has a stimulant effect, increasing alertness, talkativeness, and outward behaviors. Recreationally it is used to increase energy, sociability, and produce feelings of happiness, well-being, relaxation, and euphoria. Individuals may also use Kratom, as opposed to other opioids, to bypass routine drug tests which may not selectively test for mitragynine. It is available as raw leaves, crushed or powdered leaves, liquid extracts, capsules, and tablets. Paste-like extracts and resins are prepared by boiling off the water from aqueous leaf suspensions. Various preparations can be purchased online or from various outlets. It is not a federally scheduled compound under the United States Controlled Substance Act. However, it is controlled in some States.
**Note:** Point out Kratom is a controlled substance in some states, but not nationally. Clarification may be needed regarding Kratom sales, use and possession.

People under the influence of Narcotic Analgesics exhibit slow deliberate movements. They have difficulty concentrating and can be slow to respond to questions.

**Expected Results and Observation/Indicators of Narcotic Analgesic Impairment:**

**Psychophysical Indicators of Impairment**

- Divided attention impairment
- Poor coordination and balance

**Eye Indicators:**

- No nystagmus
- Pupils will be small (constricted)
- Droopy eyelids (“ptosis”)

**General Indicators:**

- Injection marks (“Track marks”)
- “On the nod” (Semi-conscious state)
- Slowed reflexes
- Low, slow, raspy speech
- Facial itching
- Dry mouth
- Euphoria
- Flaccid muscle tone

**Psychological effects:**

- Euphoria
- Relief from pain
- Relief from the symptoms of withdrawal

### General Impairment Indicators

- Injection marks (“Track marks”)
- “On the nod” (Semi-conscious state)
- Slowed reflexes
- Low, slow, raspy speech
- Constricted pupils

### Generalized Effects

- Euphoria
- Relief from pain
- Relief from the symptoms of withdrawal
Other Conditions That May Mimic Narcotic Analgesic Impairment Symptoms:

- Extreme fatigue
- Head injury
- Hypotension (abnormally low BP)
- Severe depression
- Diabetic reaction (“insulin shock”)

Possible Overdose Symptoms:

- Slow and shallow breathing
- Clammy skin
- Bluish colored lips
- Pale or bluish colored body parts
- Extremely constricted pupils

Signs and Symptoms of Withdrawal:

- Chills
- Aches of the muscle or joints
- Nausea
- Sweating
- Goose bumps
- Yawning
- Tearing of the eyes
- Runny nose
- Vomiting

Methods of Ingestion:

- Injected
- Smoked
- Snorted
- Suppositories
- Oral
- Transdermal absorption

Duration of Effects:

- Heroin
  - Onset: 5 - 30 minutes
  - Duration: 4 - 6 hours
- Methadone
  - Onset: 5 - 30 minutes
  - Duration: Up to 24 hours

- Fentanyl
  - Onset: 5 - 15 minutes
  - Duration: 2 – 3 hours

- Others – Vary

**Note:** Solicit questions regarding Narcotic Analgesics

### Inhalants

Inhalants are breathable chemicals that produce mind-altering results. They are also referred to as “deliriants” and comprise a wide variety of substances and delivery methods: volatile liquids that give off fumes, gases that come in pressurized tanks or bottles, and aerosol cans that are sprayed.

Inhalants vary widely in terms of chemical composition and specific effects produced. They are popular, especially with younger people, because they are cheap, quick acting, and readily available.

The effects produced depend on the chemical nature of the inhaled substance. Effects may be similar to those of a stimulant, depressant or hallucinogen.

Within this training, there are three sub-categories of inhalants:

- Volatile solvents (gasoline, paint thinner)
- Aerosols (hair spray, keyboard cleaner)
- Anesthetic gases (Ether, Nitrous Oxide)
- Volatile solvents: Comprised mostly of carbon- and hydrocarbon-based compounds that are volatile (turn to gas) at room temperature. They include such substances as gasoline, gasoline additives, butane, kerosene, glues and plastic cements, nail polish remover, paint thinners, cleaning fluid and many others. Volatile solvents are quick acting; they are absorbed into the blood almost immediately after inhalation and within 7 – 10 seconds move to the heart, liver, brain, and other tissues.

Volatile solvents are exhaled by the lungs usually leaving a telltale odor on the user’s breath.

- Aerosols: Includes spray substances such as hair spray, insecticides, paints (metallic paints), air dusters, computer keyboard cleaners (Dust-Off® and Endust®), and analgesic/asthma sprays.

Many of the volatile solvent and aerosol substances share two major volatile compounds, toluene and trichloroethylene. Toluene (methyl benzene) is the most frequently abused solvent because it is found in many substances. Trichloroethylene (TCE) is a common organic solvent and an ingredient in correction fluids, pains, antifreeze, metal degreasers and spot removers.

- Anesthetic Gases: Includes ether, nitrous oxide (“Whippets,” “laughing gas,” “nitrous”), and various nitrates which include amyl nitrite and butyl nitrite.

Nitrates and amyl nitrite have a sweet odor when fresh but a “wet-dog” or spoiled banana smell when stale. Amyl nitrite is available only by prescription.
Butyl and propyl nitrites are banned in the U.S. However, variants of these formulations are still sold as room deodorizers and shoe cleaners. Nitrates are sometimes called “poppers” because amyl nitrates were formerly packaged in glass capsules wrapped in cotton, and they broke open with an auditable popping sound.

**Note:** If time allows, discuss various forms of inhalants especially considering that many different inhalants are abused by younger people.

People under the influence of inhalants typically exhibit impairment similar to alcohol intoxication. Using inhalants is commonly referred to as “Huffing” or “Chroming.” Chroming involves inhaling toxic chemicals through the nose or mouth in order to get a temporary high. These substances can be found in aerosol cans, paint, permanent markers, acetone, hairspray, deodorants, lighter fluid, glue, or cleaning products.

Expected results of observation/indicators of Inhalant impairment include:

**Psychophysical Indicators:**
- Divided attention impairment
- Poor coordination and balance

**Eye Indicators:**
- HGN will usually be present
- Vertical nystagmus may be present (high dose for that individual)
- Pupil size may be normal, possibly dilated (anesthetic gases may cause dilation)

**General Indicators:**
- Odor of inhaled substance
- Dizziness/numbness

### General Indicators
- Odor of inhaled substance
- Dizziness, numbness
- Traces of substance around the face and nose
- Bloodshot, watery eyes
- Distorted perception, time and space
- Traces of substance (face, nose, hands)
- Bloodshot, watery eyes
- Distorted perception, time, and space
- Inebriation similar to alcohol intoxication
- Intense headache
- Nausea
- Possible hallucinations
- Slurred speech

Other Conditions That May Mimic Inhalant Impairment Symptoms:
- Severe head injury
- Inner ear disorder

Possible Overdose Symptoms:
- Coma

Methods of Ingestion:
Inhalants are ingested into the body through inhalation. There are various inhalation methods that include:
- Sniffing – use directly from the container through the nose
- “Bagging” – inhaling fumes from solvent-soaked material placed in a paper or plastic bag
- “Balloons and crackers” – inhaling from a balloon filled with nitrous oxide or other “cracking” devices used to puncture the gas canisters

Duration of Effects:
- Onset is typically immediate
  - Duration
    - Nitrates: Up to 20 minutes (Amyl, Butyl, “Rush”)

More General Indicators
- Inebriation similar to alcohol intoxication
- May complain of intense headache
- Nausea
- Possible hallucinations
- Slurred speech

Conditions with Similar Symptoms
- Severe head injury
- Inner ear disorders

Methods Of Ingestion

Duration of Effects
- Nitrates Immediate Up to 20 minutes
- Nitrous Immediate 5 minutes or less
- Oxide
- Volatile Immediate Several hours
- Solvents
Nitrous Oxide: 5 minutes or less
Volatile solvents: Several hours (gasoline, paint)

**Note:** Solicit questions regarding Inhalants

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**Cannabis**

Cannabis is a term that refers to marijuana and other drugs made from the Cannabis Sativa plant.

Strong forms of cannabis include Sinsemilla, hashish ("hash" for short), and hash oil.

Marijuana, which is part of the cannabis drug category, is a green, brown, or gray mixture of dried, shredded leaves, stems, seeds, and flowers of the Cannabis Sativa plant. There are many different slang terms for marijuana and, as with other drugs, they change quickly and vary from region to region.

No matter its form or label, all cannabis products contain the primary psychoactive (mind-altering) chemical delta-9-tetrahydrocannabinol (THC). Marijuana contains more than 400 other chemicals, many of which are not well known or studied. THC is the chemical in marijuana responsible for producing the euphoria or the “high.”

Cannabidiol (CBD) is another chemical in marijuana and is considered non-psychoactive and lacks the intoxicating properties of THC. There is some evidence that CBD may hold medicinal value to treat several medical
conditions such as neurological disorders (i.e., seizures and epilepsy), psychosis and anxiety.

Although the current national THC average level of smokable marijuana is approximately 15%, some states report recreational marijuana samples testing at 30%. This does not include high-potency extract concentrates, which can have 80-95% THC content. (Source: DEA Marijuana Fact Sheets, 2022)

According to the National Survey on Drug Use and Health, marijuana is one of the most used drugs in the United States, and its use is widespread among young people. In 2021, 35.4% of young adults aged 18 to 25 (11.8 million people) reported using marijuana in the past year. According to the Monitoring the Future survey, in 2022, 30.7% of 12th graders reported using marijuana in the past year and 6.3% reported using marijuana daily. In addition, many young people also use vaping devices to consume cannabis products. In 2022, nearly 20.6% of 12th graders reported that they vaped marijuana in the past year and 2.1% reported doing so daily.

Therefore, marijuana use among young people remains a major concern and is the focus of continuing research, particularly regarding its impact on brain development, which continues into a person’s early twenties. Some studies suggest that the effects of heavy use that begins as a teen can be long lasting, even many years after use discontinues.

When people smoke marijuana, they feel its effects almost immediately. THC rapidly reaches every organ in the body, including the brain, and attaches to specific receptors on nerve cells.

THC is chemically similar to chemicals that the body produces naturally, called endocannabinoids. THC disrupts the normal...
function of these chemicals. Because of this system’s wide-ranging influence over many critical functions, marijuana can have multiple adverse effects — not just on the brain, but on a person’s general health.

Some of these effects last only as long as marijuana is in the body while others may build up over time to cause longer-lasting problems, including addiction.

Various Types of Cannabis

There are many forms of cannabis today, and the market continues to evolve. Various forms include:

- Leaves, Stems and Buds – Generally, this form of marijuana is rolled into a joint or cigarette or put into a pipe or bong to smoke. Smoking the plant is one of the most often used ingestion methods. With the leaf form of marijuana, the quality can vary widely. Some leaves, stems, and buds are very potent, while others are not. Forms include Sativa, which known for causing an energetic and emotional uplifted high; Indica, which is known for having a “body high” often causing deep relaxation sometimes referred to as “couch-lock.”

- Shatter – A concentrated form made from a butane extraction process where the butane is pushed through marijuana buds and the remaining substance is left as a sheet. Once cooled and dried, it is broken into shards, called shatter.

- Wax – A concentrated form developed by extraction that produces a firm and waxy substance. Designed to be smoked but can be 20 to 30 times stronger than traditional marijuana.
• Crumble – A concentrated form when butane is whipped with cannabis wax.

• Hash Oil ("honey oil") – A concentrate made into a runny oil made from CO2.

• Water Hash – A concentrate made by mixing marijuana with cold water and ice to eliminate trichome heads.

• Edible cannabis or marijuana - Consumed in various foods and often manufactured to replicate or appear to be a popular edible product.

• Synthetic cannabinoids – Includes many different names or identifiers. Spice and similar products consist of shredded dried plant material that has been sprayed with chemicals designed to act on the same brain cell receptors as THC but are often much more powerful and unpredictable. These products are typically labeled "not fit for human consumption," and most are illegal. But their manufacturers are constantly creating new chemical compounds to sidestep legal restrictions.

One use of THC is called “Dabbing” which is a concentrated, high potency form of THC. Dabbing is a way to get the quickest, longer-lasting high with a single inhalation, usually from a vaping device or vape pen. A single puff from a pipe or vaping pen can give the effect of smoking numerous joints. Unfortunately for parents, teachers and law enforcement, the new vaping pens make it extremely difficult to see, smell or detect.

It involves the use of butane or other various chemicals to heat and refine the THC into “BHO” or butane hash oil. The resulting waxy ball of
THC is then heated or put into a vaporizing pen and inhaled. Many concentrates can have THC levels that exceed 90%. This ingestion method can affect the user for 4 – 5 hours.

**Other Types or Forms of Cannabis:**

- Sinsemilla (Potent form made from unfertilized female plants)
- Hashish (Concentrated version of marijuana)
- Dronabinol (Marinol), Sativex, and Cesamet (Synthetic forms of THC)

**Note:** Point out Cannabis can come in many forms or types and continues to evolve. Solicit questions regarding the various forms and how each is used.

People under the influence of Cannabis are typically relaxed, care-free acting and will exhibit divided attention impairment.

**Note:** If internet is available, play the video “Your Brain on Marijuana” which can be accessed using the website link in the PowerPoint. The video is approximately 2 minutes and 25 seconds in length.
Expected Results of Observations/Indicators of Impairment:

<table>
<thead>
<tr>
<th>Psychophysical Indicators:</th>
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<tbody>
<tr>
<td>o Divided attention impairment</td>
</tr>
<tr>
<td>o Poor coordination and balance</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Eye Indicators:</th>
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</thead>
<tbody>
<tr>
<td>o No nystagmus</td>
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<tr>
<td>o Pupil size will be dilated, but may be normal</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>General Indicators:</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Odor of marijuana</td>
</tr>
<tr>
<td>o Relaxed inhibitions</td>
</tr>
<tr>
<td>o Marked reddening of the eyes</td>
</tr>
<tr>
<td>o Body tremors</td>
</tr>
<tr>
<td>o Disorientation</td>
</tr>
<tr>
<td>o Attention difficulties</td>
</tr>
<tr>
<td>o Impaired perception of time and distance</td>
</tr>
<tr>
<td>o Marijuana debris in the mouth</td>
</tr>
<tr>
<td>o Eyelid tremors</td>
</tr>
<tr>
<td>o Increased appetite</td>
</tr>
</tbody>
</table>

Other Conditions That May Mimic Cannabis Impairment Symptoms:

| o Some medical conditions can be associated with a lack of attention. An example would be attention deficit hyperactivity disorder (ADHD). |

Possible Overdose Symptoms:

| o Acute anxiety attacks |
| o Paranoia |
| o Possible psychosis |
| o Excessive vomiting (Cannabinoid Hyperemesis Syndrome) |
Long-term Effects on Cannabis Use:

- Lung damage
- Chronic bronchitis
- Lowering of testosterone
- Chronic reduction in attention span
- Withdrawal is similar to alcohol dependence withdrawal

Methods of Ingestion:

- Smoked (Vaping)
- Oral
- Transdermal (patches)

Duration of Effects

- Smoked Cannabis — immediate onset and 3 to 4 hours duration of effects
- Edibles: Onset of 1-3 hours with duration of effects lasting up to 8 hours
- Concentrates: Vary depending on the form of the concentrate and THC potency

**Note:** Point out trying to pinpoint precise onset and duration of effects for cannabis vary and depend on the THC content and the users experience with the drug.

Also point out that urine tests that detect THC do not necessarily relate to impairment as the THC can be detected weeks after the person’s use of the cannabis product.

**Note:** Solicit questions regarding Cannabis
C. Drug Combinations

Polydrug use refers to the use of two or more psychoactive drugs in combination to achieve a particular effect.

There are various reasons for combining drugs. Some include 1) One drug is used as a base or primary drug with additional drugs to compensate for the side effects of the primary drug, 2) Make the experience more pronounced, 3) To supplement for a primary drug when supply is low or not available (“The next best thing”), and 4) Lack of understanding about the effects of combining drugs.

Combining drugs is often referred to with different titles, such as polypharmacy, polysubstance and polycategory. For our purposes, polydrug is used and is defined as:

“Having two or more drugs in the body at the same time.”

It is becoming more common to encounter polydrug users than single drug users. One of the most common polydrug combinations is marijuana and alcohol. According to the National Cannabis Prevention and Information Center (NCPIC), a person combining both can experience the same symptoms but to an unpredictable level. This may be due to the psychedelic properties of marijuana, which affect the mind in different ways. These effects may be heightened with the sedative effect of alcohol, thus increasing the risk for psychological and psychotic symptoms. The NIPIC also reported that alcohol can increase the absorption of THC. The combination can produce significantly higher THC levels than cannabis alone. (Source: Research Shows That Any Dose of Alcohol Combined With Cannabis Significantly Increases Levels of THC in the Blood, AACC, May 27, 2015).
**Note:** If internet is available, access the video “Drunk and High” using the website link in the PowerPoint slide. The video is approximately 2 minutes and 30 seconds in length. (Video may contain advertisements that can be skipped)

Of the Drug Recognition Expert (DRE) evaluations entered in the National DRE tracking system, approximately 37 percent of are identified as polydrug users. (Source: IACP DRE 2022 Annual Report)

Drug combinations often produce conflicting signs and symptoms. Combining drugs as it relates to causing impairment can be described in four types of effects: 1) Null Effect, 2) Overlapping Effect, 3) Additive Effect, and 4) Antagonist Effect.

**Note:** The four drug effects are covered in more detail in Day 2 of this training. If both days of the training are being conducted, more emphasis can be put on this topic using that Session in Day 2.

In layman terms, Null Effect would be when neither drug results in an action. Overlapping Effect would be when an action of a drug plus no action of the other drug would equal an action. Additive Effect would be when each drug causes an action, and the action is therefore greater. Antagonistic Effect would be when an action of one drug has an opposite action, and the result may be unpredictable.

An example of an Antagonistic Effect would be pupil size when a person under the influence of methamphetamine (CNS Stimulant) and fentanyl (Narcotic Analgesic) could have pupils that are small (constricted), large (dilated) or normal in appearance.

**Note:** Point out not to discount something because the signs and symptoms you see do not fit into any specific category.
**Note:** If time allows, review the Drug Symptomatology Chart at the end of this session with the participants. Solicit questions regarding drug combinations.

### Conclusion of Session IV

<table>
<thead>
<tr>
<th>Questions Regarding Drug Combinations and Drug Symptomology Chart Review</th>
</tr>
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</table>

**Note:** Solicit questions regarding information covered in Session IV.
<table>
<thead>
<tr>
<th>Impairment Indicators</th>
<th>CNS Depressants</th>
<th>CNS Stimulants</th>
<th>Hallucinogens</th>
<th>Dissociative Anesthetics</th>
<th>Narcotic Analgesics</th>
<th>Inhalants</th>
<th>Cannabis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Anxiety</td>
<td>Body tremors</td>
<td>Blank stare</td>
<td>Depressed reflexes</td>
<td>Bloodshot eyes</td>
<td>Bloodshot eyes</td>
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<tr>
<td>GENERAL INDICATORS</td>
<td>Body tremors</td>
<td>Dazed appearance</td>
<td>Chemical odor</td>
<td>Difficulty concentrating</td>
<td>Dizzy</td>
<td>Body tremors</td>
<td></td>
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<tr>
<td></td>
<td>Euphoric</td>
<td>Difficulty with speech</td>
<td>Disoriented</td>
<td>Dropped eyelids</td>
<td>Confused</td>
<td>Disoriented</td>
<td></td>
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<tr>
<td></td>
<td>Talkative</td>
<td>Disoriented</td>
<td>Hallucinations</td>
<td>Drowsiness</td>
<td>Dry mouth</td>
<td>Drowsiness</td>
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<tr>
<td></td>
<td>Exaggerated</td>
<td>Hallucinations</td>
<td>Impaired perception</td>
<td>Emotional</td>
<td>Euphoria</td>
<td>Euphoria</td>
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<td></td>
<td>shutter</td>
<td>of time and distance</td>
<td>of time and distance</td>
<td>pain</td>
<td>Facial itching</td>
<td>Eyelid tremors</td>
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<tr>
<td></td>
<td>reflexes</td>
<td>Memory loss</td>
<td>Nausea</td>
<td>Non-communicative</td>
<td>“On the nod”</td>
<td>Non-communicative</td>
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<tr>
<td></td>
<td></td>
<td>Paranoia</td>
<td>Perspiring</td>
<td>Euphoria</td>
<td>Slow deliberate</td>
<td>Odor of substance</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Synesthesia</td>
<td>Possibly violent</td>
<td>Nausea</td>
<td>movements</td>
<td>Possible nausea</td>
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<td></td>
<td></td>
<td>Uncoordinated</td>
<td>Slow, slurred speech</td>
<td>Slow</td>
<td>Residue of substance</td>
<td>Residue of substance</td>
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<td></td>
<td></td>
<td>Restlessness</td>
<td>speech</td>
<td>Slurred speech</td>
<td>Euphoria</td>
<td>Water eyes</td>
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<td></td>
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<td>Talkative</td>
<td>Slowed responses</td>
<td>Slow breathing</td>
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<td>Lack of concentration</td>
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<td></td>
<td></td>
<td></td>
<td>Possible paranoia</td>
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<tr>
<td>DURATION OF EFFECTS</td>
<td>Barbiturates:</td>
<td>Cocaine:</td>
<td>LSD: 6-8 hours</td>
<td>Fentanyl: 2-3 hours</td>
<td>Anesthetic gases</td>
<td>Edibles: Up to 8</td>
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<tr>
<td></td>
<td>1-16 hours</td>
<td>LSD: 6-8 hours</td>
<td>MDMA: 1-3 hours</td>
<td>Herion: 3-5 hours</td>
<td>and aerosols - very short</td>
<td>hours</td>
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<tr>
<td></td>
<td>Tranquillizers:</td>
<td>Meth:</td>
<td>Ketamine: Up to 2 hours</td>
<td>PCP: 4 – 6 hours</td>
<td>duration.</td>
<td>Smoked: 3-4 hours</td>
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<tr>
<td></td>
<td>4-8 hours</td>
<td>Up to 12 hours</td>
<td>Psilocybin: Up to 5 hours</td>
<td>Others: Vary</td>
<td>Several hours for</td>
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<td></td>
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<td>D: 6-24 hours</td>
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<td>volatile solvents</td>
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<td>D: 6-24 hours</td>
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<td>Oral</td>
<td>Injected</td>
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<td>Injected</td>
<td>Insufflation</td>
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<td>Insufflation</td>
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<td>Smoked</td>
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<td>(intranasal)</td>
<td>(snorting)</td>
<td>Oral</td>
<td>Oral</td>
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<td>Transdermal</td>
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<td>Oral</td>
<td>Smoked</td>
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<td></td>
<td></td>
<td>Transdermal</td>
<td>Transdermal</td>
<td>Transdermal</td>
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<td>Transdermal</td>
<td></td>
</tr>
<tr>
<td>OVERDOSE SIGNS</td>
<td>Clammy skin</td>
<td>Hallucinations</td>
<td>Condition similar to</td>
<td>Coma</td>
<td>Cardiac arrhythmia</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coma</td>
<td>Psycosis</td>
<td>heat stroke</td>
<td>Seizures</td>
<td>Nausea/vomiting</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rapid, weak</td>
<td>Violent</td>
<td></td>
<td>Coma</td>
<td>Respiration ceases</td>
<td>Excessive vomiting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>pulse</td>
<td>behavior</td>
<td></td>
<td>Convulsions</td>
<td>Risk of death</td>
<td>Possible psychosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Shallow</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Acute anxiety attacks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>breathing</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
**Session V**

POLICIES, PROCEDURES, ROLES, AND CONTACTING PARENTS

**Objectives**

Upon successfully completing this session, participants will be better able to

1. Understand their roles as team members in the awareness and identification of impaired individuals.

2. Become familiar with general observations and behavioral changes that may indicate substance abuse.

3. Understand the processes used in determining substance impairment.

4. Discuss local issues regarding possession and use of drugs in the school.

5. Share the results of the drug assessment with parent(s).

6. Assist the parent(s) in identifying referral resources.

7. Become familiar with commonly used drug concealment methods.

<table>
<thead>
<tr>
<th>Content Segments:</th>
<th>Learning Activities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Review of School Policy</td>
<td>○ Instructor Led Presentations</td>
</tr>
<tr>
<td>B. What to Do When You Suspect a Student is Using Drugs</td>
<td></td>
</tr>
<tr>
<td>C. School Team Effort</td>
<td></td>
</tr>
<tr>
<td>D. First Contact</td>
<td></td>
</tr>
<tr>
<td>E. Intent of This Training Program</td>
<td></td>
</tr>
<tr>
<td>F. Contacting the Parent(s)</td>
<td></td>
</tr>
<tr>
<td>G. Interview with the Parent(s)</td>
<td></td>
</tr>
<tr>
<td>H. Words to Use When Talking to Parents</td>
<td></td>
</tr>
<tr>
<td>I. Words That May Cause a Negative Reaction from Parent(s)</td>
<td></td>
</tr>
<tr>
<td>J. Substance Abuse Considerations</td>
<td></td>
</tr>
<tr>
<td>K. Drug Concealment Methods</td>
<td></td>
</tr>
</tbody>
</table>

Drug Impairment Training for Education Professionals – Instructor Guide
IACP 8/2023
**Note:** For this session it will be beneficial to have a copy of the district or school policy on possession of drugs and students under the influence of drugs.

### A. Review of School Policy

Remember: Always follow your district and/or school policy when dealing with drug-impaired individuals.

**Pose question:** 1) Does your school district have a policy on possession of drugs? 2) If so, does it address students under the influence of drugs?

Serious consideration should be given to the development and implementation of a written policy if one is not in place.

An ideal policy should include the following:

- Prohibiting the unlawful manufacture, distribution, dispensing, possession, use, sale, purchase, consumption, or being under the influence of a controlled substance on school property or as part of any school sponsored activity.

- Prohibiting the abuse of prescription drugs as well as the illegal use, purchase, sale or attempted sale of prescription drugs.

- Prohibiting the use of alcoholic beverages while on school premises, including meal periods and breaks.

- Prohibiting being under the influence of alcohol at any school function.

- Prohibiting the use or being under the influence of unauthorized drugs while attending school approved functions and that a violation of this policy will constitute grounds for disciplinary action and/or referral to law enforcement and prosecution.

**Note:** If available, bring copies of the local laws and ordinances related to drug free zones and possession of drugs at or near school grounds.
**Note:** Address any differences between state school laws, state nursing laws, and state criminal laws. Ethical and reporting requirements may be different for disciplinary versus medical procedures. Be able to address these kinds of questions.

**Note:** Point out the importance of participants knowing and understanding their school’s policies. Also, inform the participants that they should review the policies after this training to ensure they are consistent with what they can do after the training.

**Note:** If available, have the school superintendent or principal talk about their policy and procedure involving drug possession and impairment.

### B. What to Do When You Suspect a Student is Using Drugs

If the student is taking his/her prescribed medication at the recommended dosage, the student should not be impaired.

**Note:** Point out that the participants should gather as much information as possible to substantiate any suspicions.

Observations and changes that may indicate drug abuse:

- **Social/Behavioral symptoms:** may include changes in emotional functioning such as depression, irritable mood, nervousness, euphoria, and apathy.

- **Cognitive functioning:** may include poor concentration, sensation of slowed time, confusion, rambling flow of thoughts and speech, poor memory, and attention.

- **Biological/Physical symptoms:** may include changes in the student’s ability to self-regulate, changes in heart rate, blood pressure, appetite, and weight; muscle twitching, weakness, or tremors: seizures, lack of coordination, dizziness, blurred vision, dilated or constricted pupils; red, glassy eyes, sweating, nausea, vomiting, respiratory distress, and chills.
- Psychomotor agitation: may include pacing, hand wringing, picking at skin, fidgeting, and restlessness.

- Psychomotor delay: may include listlessness, slowed speech, thinking or body movements and deterioration of handwriting.

- Emotional/Cognitive symptoms: may include changes in behavioral functioning, increased combativeness and competitiveness, lethargy, discontinuation of previously enjoyed activities, becoming more secretive, and engaging in lying behavior.

- Changes in social functioning: may include involvement in a sudden new peer group or marked isolation from peers.

**Note:** Point out there may be other reasons in the student’s life that would account for changes you observe (death in the family, domestic violence, divorce of parents, move, etc.).

If possible, discuss your observations with others having contact with the student.

Others may have made observations similar to, or in addition to, what you have seen.

Be discreet when making your inquiries.

Public queries may be misinterpreted as fact or an accusation.

Be careful not to place additional stress on the student and do not accuse the student.

**Note:** Avoid public announcements in class or other areas where you would or could be overheard discussing this issue.
Make your observations and get the facts using the best resources available to you - Just the facts.

**C. School Team Effort**

It is important to have designated roles and understand those roles, especially if a drug influence evaluation is conducted by a school staff person. This would include designating the examiner, observers and witnesses to evaluation made by school staff.

**Note:** This is time to have an open discussion about team “roles” and who would do what, to include conducting the evaluation and serving as an observer or witness.

The school team typically includes:

- **School Teachers**
  - First line of defense
  - Encounter the student daily
  - Observe physical and behavioral changes
  - Discuss your observations with others having contact with the student
  - Document your observations
  - Escort the student to the nurse’s or administrator’s office

- **School Counselors**
  - Review the student’s academic record, attendance, and other similar incidents
  - Meet with the student, parent(s), administrators, and other involved parties
  - Involve the parent(s)
  - Identify the substance abuse treatment options
  - Follow up with the student’s progress
<table>
<thead>
<tr>
<th>- School Principals, Deans, Administrators</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Take appropriate action consistent with the school’s policies</td>
</tr>
<tr>
<td>o Include all applicable team members</td>
</tr>
<tr>
<td>o Consider the observations of the teacher, counselor, and nurse</td>
</tr>
<tr>
<td>o Consider the welfare and safety of the entire student/staff body</td>
</tr>
</tbody>
</table>

**Note:** Stress the importance of reviewing and following the current policy(s) of the school.

<table>
<thead>
<tr>
<th>- School Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Listen to the teacher’s observations</td>
</tr>
<tr>
<td>o Interview the student.</td>
</tr>
<tr>
<td>▪ Medical questions.</td>
</tr>
<tr>
<td>▪ Clinical assessments</td>
</tr>
<tr>
<td>o Document your observations</td>
</tr>
<tr>
<td>o Inform administrators of the situation and present your observations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>- Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Emergency medical personnel</td>
</tr>
<tr>
<td>o School Resource Officers (SROs)</td>
</tr>
<tr>
<td>o Security</td>
</tr>
<tr>
<td>o On-Duty law enforcement personnel</td>
</tr>
</tbody>
</table>

**Note:** The process may be initiated by any member of the team. Any one of the team can make the observations and document them. Stress a team concept to approach the problem.

**Note:** Participants will need to be better observers by utilizing all of their senses. Their input will be included in the overall assessment of the student. Follow school policy.
D. First Contact:

To take appropriate action and assist a student suspected of substance impairment, it is necessary to be familiar with the signs and symptoms of an alcohol or other drug problem. However, it is important to remember that you are not expected to be an expert in this area, nor are you expected to be able to diagnose a student’s problem.

The first step in helping a student is simply to recognize that a problem may exist and contact the student (Intervention).

Intervention is a proactive method used to increase awareness of problem behaviors, prevent problems from becoming worse, and promote referral for further assessment and possible treatment. Intervention simply means meeting with a student and discussing your concerns. The following are some tips for conducting an informal intervention:

- Select a private location
- Let the student know that you are genuinely concerned
- Describe to the student the specific behaviors that caused your concern
- Speak to the student in an objective, nonjudgmental manner
- Be prepared for the student to provide excuses, promise behavior change, attempt to redirect the conversation, or pass the problem off as no big deal
- Document your contact with the student
### Intervention Tips:

- Avoid lecturing and admonishing
- Having a positive attitude towards the student
- Avoid judgmental responses
- Avoid medical jargon
- Be attentive, genuine, and empathic
- Identify the problem
- Avoid writing during the contact, especially during sensitive questions
- Criticize the activity, not the student and highlight the positive

Remember that even if the student refuses your help, you are an important part of the process in helping him/her recognize that there is a problem. If you are uncomfortable intervening with the student yourself but would still like to help, involve another member of the team.

As part of this training, school nurses will receive training to conduct an assessment. An integral part of this assessment is an interview of school personnel who have observed signs and symptoms of the student prior to arrival at the health office.

**Note:** Refer the participants to “Referral Form” at the end of Session VI, labeled Appendix 6D” in the Participant Manual.

### E. Intent of This Training Program:

The primary intent of this training is to assist teachers, administrators, security personnel and medical practitioners in identifying drug impaired students. This enables you to assist students that may need help and at the same time help keep the school environment safe.

**Note:** Point out that it is not the intent to turn participants into “Hallway Narcs.”

**Note:** Emphasize that the information received may make the difference in their ability to identify a student who is drug-impaired and a danger to his/herself and others.
<table>
<thead>
<tr>
<th>Possession of drugs is a crime.</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Having drugs in your school system may or may not be against the law depending on state laws</td>
</tr>
<tr>
<td>o However, driving under the influence of drugs is illegal in every state</td>
</tr>
</tbody>
</table>

**Note:** Identify and be prepared to discuss local statutes regarding the possession of drugs, and drugged driving.

**Pose question:** “Over the last year, do you know of any students that were involved in, or suspected of being in a drug/alcohol-related crash?”

<table>
<thead>
<tr>
<th>Drug-Free School Zone</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drug-Free School Zones</strong></td>
</tr>
<tr>
<td>A geographical area where the distribution or possession of controlled substances is penalized with a sentence or fine greater than is applicable elsewhere.</td>
</tr>
</tbody>
</table>

**Note:** Review the state drug-free school zone statutes.

<table>
<thead>
<tr>
<th>United States Federal law and many state and local laws increase penalties for illegal drug-related activities in Drug-Free School Zones.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Drug-Free Zone is a geographical area where the distribution or possession of controlled substances is penalized with a sentence or fine greater than is applicable elsewhere. Areas classified as drug free zones are generally specified in a state’s drug offense laws. Ordinarily, areas within a certain distance from a school or other place where children are found is classified as a drug-free zone. If an individual is arrested for the possession or distribution of a controlled substance within the drug-free zone, the penalties for the offense are enhanced.</td>
</tr>
<tr>
<td>The issue of school safety is a shared concern.</td>
</tr>
</tbody>
</table>
Today, more than ever, it is essential that communities, businesses, parents, and students work together to develop a disciplined environment where learning can take place in a safe and drug-free school.

**Note:** Point out that students don’t necessarily use drugs at school. They use drugs away from the school grounds and then operate a vehicle under the influence of those drugs.

### F. Contacting the Parents(s):

This section deals with the WHO, WHAT, and WHERE determined ahead of time by individual school policy.

- WHO will call the parent(s)?
- WHAT is your school policy regarding discipline for students under the influence of impairing substances on school property or at school sponsored events?
- WHERE can parent(s) go for help in your community?

**Pose question:** “Does your school policy prevent a student who is under the influence of drugs to drive their vehicle off school property?”

**Pose question:** “What do you do if the parent comes to pick up the student and the parent appears to be under the influence or impaired?”

### G. Interview with the Parents(s):

Often parents come to the health care professional with requests for help with parenting their teens. Helpful suggestions include:

Guidelines for the interview with the parent(s) or guardian:

- Document your contact
- Express your concerns by showing interest in the student and their welfare
- Avoiding lecturing or “talking down”
- Stress positive attributes of the student in question
- Listen to the parent(s) or guardian and treat their comments seriously
- Avoiding comparing their child with other students
- Do not accuse!

**Note:** Point out that it’s important to advise the parent(s) that you have received training in reference to this matter. Be specific about your observations and why they indicate possible drug use.

- Offer the parent(s) referrals to available resources

**Note:** Instructors should contact local police or other agencies to have a list of local resources parent(s) should use. Many times, police or schools will have these. A check with juvenile authorities may help in this area.

- Be supportive and aware that parent(s) may deny students use of drugs.

**Note:** Some parents or guardians may be completely unaware of the student’s drug use. Others may not have known what to do about it. Don’t blame them, help them if possible.

**H. Words to Use When Talking with Parents(s) or Guardian:**

- Concern
- We observed...
- Appearance of...
- Sleepy acting, Lethargic, Non-communicative, etc. (Be specific)
- Safety
- Assistance
I. **Words that May Cause a Negative Reaction from Parents(s):**

- Diagnosed
- Drugs
- High
- Drunk
- Druggie
- Suspect
- Arrest
- Out of Control
- Crazy
- Jail
- Others?

**Note:** Point out during this training, we use the words, “drugs”, “impaired” and “assessed”. However, these terms may trigger a negative reaction with parents.

<table>
<thead>
<tr>
<th>Words Which May Result in a Negative Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosed</td>
</tr>
<tr>
<td>Drugs</td>
</tr>
<tr>
<td>High</td>
</tr>
<tr>
<td>Drunk</td>
</tr>
<tr>
<td>Druggie</td>
</tr>
<tr>
<td>Suspect</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

J. **Substance Abuse Considerations:**

Schools should consider having a substance abuse prevention (SAP) and intervention policy that is focused on improving the health and well-being of their students.

As soon as you suspect substance use in a student, consult with your school SAP or mental health staff.

If substance abuse is suspected, the school may want to refer the individual to the school counselor(s) if available.

There may times parents may also suspect substance abuse. However, treatment may be expensive or not covered by insurance, therefore they don’t follow-up or pursue the options.

It is recommended that you know what local community resources are available.
### K. Drug Concealment Methods:

The ways in which drug users hide or conceal their drugs has evolved through the years. This includes various clothing types as well as devices that may appear harmless and legal. Therefore, it is important to know of some common and popular methods of concealing drugs, especially in the school environment.

One popular method is called “stash clothing.” This involves hiding drugs in clothing that can be easily accessed, usually in a pocket, sleeve or sewn into clothing or hats. The advantage of this method is that it allows users to keep their drugs close at hand without being obvious. Sometimes users may take it to a higher-level wearing clothing brands that specialize in concealment methods. These clothes are often sold online and in retail stores.

Some of the most popular garment types for stashing drugs include a hoodie that features a hidden hood pocket; undercover stash bras with a hidden pocket that can be used as a drug pocket; stylish bags and purses with hidden compartments that are used to conceal lighters, vape pens, and marijuana.

Males also hide drugs in intimate pieces of clothing, including underwear briefs that feature a hidden compartment on the crotch. Other unique clothing includes hoodies that connect to vape cartridges where the users can vape through the hoodie’s drawstring. Other apparel includes a range of boots with large front pockets where drugs can be hidden. Others include belts that have hidden pockets.

Although the clothes or other articles may not have been made explicitly for drug concealment, they are well known for their ability to hide contraband and some manufacturers promote them as such.
### Conclusion of Session V

#### Questions Regarding Contacting the Parents?

**Note:** Solicit questions regarding school policy, roles and contacting the parents.
Session VI

REFERENCES

Objectives

Upon successfully completing this session, participants will be better able to

1. Access additional references and resources provided.

<table>
<thead>
<tr>
<th>Content Segments:</th>
<th>Learning Activities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Internet Resources</td>
<td>o Instructor Led Presentations</td>
</tr>
<tr>
<td>B. Printed Resources/References</td>
<td></td>
</tr>
<tr>
<td>Appendix 6A: Suggested Additional</td>
<td></td>
</tr>
<tr>
<td>References and Resources</td>
<td></td>
</tr>
<tr>
<td>Appendix 6B: Expected Duration and</td>
<td></td>
</tr>
<tr>
<td>Detectability of Drugs in Urine</td>
<td></td>
</tr>
</tbody>
</table>
There are numerous references available to teachers, administrators and school nurses regarding drugs and their various impairing effects. Some of those resources are covered in this session and include:

<table>
<thead>
<tr>
<th><strong>A. Internet Resources</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Contains specific pages for parents and teachers about drugs of abuse, drug trends, and treatment options.</td>
</tr>
<tr>
<td>Erowid - <a href="https://www.erowid.org">https://www.erowid.org</a>.</td>
</tr>
<tr>
<td>A pro-drug non-profit educational and harm-reduction resource with information about psychoactive drugs and drug effects</td>
</tr>
<tr>
<td>Government site for highway safety information and statistics</td>
</tr>
<tr>
<td>Site for legal issues and materials explaining drug assessment procedures in lay terms.</td>
</tr>
<tr>
<td>A pill identification resource site</td>
</tr>
<tr>
<td>A medical-based resource for information about drugs and “herbal” substances</td>
</tr>
<tr>
<td>A database maintained by the FDA providing information about various prescription drugs.</td>
</tr>
</tbody>
</table>
Note: Point out there are additional resources listed in the Participant Manual. Instructors may want to access some of the listed resource websites to demonstrate the information that can be accessed.

Web MD Rx –
http://www.webmd.com/drugs/2/index

- A comprehensive database of prescription drug and medication information from A to Z.


- Provides information about "family" or "class" that a particular drug belongs to.

Drug Enforcement Administration -

- Provides drug fact sheets on numerous legal and illegal drugs.

B. Printed Resources/References

- Physician’s Desk Reference
  - Available at: www.pdr.net/resources/pdr-books
- Drug Identification Bible, Amera-Chem, Inc.
  - Available at: www.drugidbible.com.
- DEA Drugs of Abuse, 2022
- Uppers, Downers, All-Arounders, CNS Productions, Inc., Medford, Oregon
  - Available at: www.cnsproductions.com
## Conclusion of Session VI

### Note: Solicit questions regarding drug resources

### Note: This concludes Day 1 of the training. If only one day of the training is being offered, use Session 11 of the curriculum to cover the Assessment portion of the training and other course closing activities.
Appendix 6A

SUGGESTED ADDITIONAL REFERENCES AND RESOURCES


Pocket Psych Drugs, D. Pedersen


DRUG INFORMATION SOURCES

National Institute of Drug Abuse
5600 Fishers Lane
Rockville, Maryland 20857

National Clearinghouse for Drug Abuse Info (NCDAI)
P.O. Box 416
Kensington, Maryland 20795

Substance Abuse and Mental Health Services Administration (SAMSHA)
Website - www.samsha.gov

International Association of Chiefs of Police (IACP) Drug Evaluation and Classification Program
Website – www.decp.org
### EXPECTED DURATION OF DETECTABILITY OF DRUGS IN URINE

<table>
<thead>
<tr>
<th>Drug</th>
<th>Retention Time Which Detectable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amphetamine/Methamphetamine</td>
<td>12-72 hours</td>
</tr>
<tr>
<td><strong>Barbiturates</strong></td>
<td></td>
</tr>
<tr>
<td>Amobarbital (Tuinal)</td>
<td>2-4 days</td>
</tr>
<tr>
<td>Pentobarbital (Fiorinal)</td>
<td>2-4 days</td>
</tr>
<tr>
<td>Phenobarbital (Nembutal)</td>
<td>Up to 30 days</td>
</tr>
<tr>
<td>Secobarbital (Seconal)</td>
<td>2-4 days</td>
</tr>
<tr>
<td><strong>Benzodiazepines</strong></td>
<td></td>
</tr>
<tr>
<td>Alprazolam (Xanax)</td>
<td>Up to 30 days</td>
</tr>
<tr>
<td>Diazepam (Valium)</td>
<td>Up to 30 days</td>
</tr>
<tr>
<td>Chlordiazepoxide (Librium)</td>
<td>Up to 30 days</td>
</tr>
<tr>
<td><strong>Cocaine Metabolites</strong></td>
<td>12-72 hours</td>
</tr>
<tr>
<td><strong>Cannabis (Marijuana)</strong></td>
<td></td>
</tr>
<tr>
<td>Single use</td>
<td>3 days</td>
</tr>
<tr>
<td>Moderate smoker (4 times/week)</td>
<td>5 days</td>
</tr>
<tr>
<td>Heavy smoker (daily)</td>
<td>10 days</td>
</tr>
<tr>
<td>Chronic smoker (daily)</td>
<td>21-27 days</td>
</tr>
<tr>
<td><strong>Opiates (Narcotic Analgesics)</strong></td>
<td></td>
</tr>
<tr>
<td>Codeine</td>
<td>2-4 days</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>1-3 days</td>
</tr>
<tr>
<td>Hydromorphone (Dilaudid)</td>
<td>2-4 days</td>
</tr>
<tr>
<td>Morphine/Heroin</td>
<td>2-4 days</td>
</tr>
<tr>
<td><strong>PCP (Ketamine)</strong></td>
<td></td>
</tr>
<tr>
<td>Casual Use</td>
<td>Up to 5 days</td>
</tr>
<tr>
<td>Chronic use</td>
<td>Up to 14 days</td>
</tr>
</tbody>
</table>

**NOTE:** Retention times may vary depending on variables including drug metabolism and half-life, patient’s physical condition, fluid intake, and method and frequency of ingestion.