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.

<table>
<thead>
<tr>
<th>Content Segments:</th>
<th>Learning Activities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Welcoming Remarks</td>
<td>o Instructor Led Presentations</td>
</tr>
<tr>
<td>B. Introductions</td>
<td></td>
</tr>
<tr>
<td>C. Goal of the Training</td>
<td></td>
</tr>
<tr>
<td>D. What is a Drug?</td>
<td></td>
</tr>
<tr>
<td>E. Training Objectives</td>
<td></td>
</tr>
<tr>
<td>F. Standardized and Systematic Procedures</td>
<td></td>
</tr>
<tr>
<td>G. Overview of the Participant Manual</td>
<td></td>
</tr>
<tr>
<td>H. Administrative Procedures</td>
<td></td>
</tr>
<tr>
<td>I. Test Your Knowledge (Pre-Test)</td>
<td></td>
</tr>
</tbody>
</table>

![Drug Impairment Training for Education Professionals (DITEP)](image)

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.

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.
### 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.
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.

<table>
<thead>
<tr>
<th>G. Overview of the Participant Manual</th>
</tr>
</thead>
<tbody>
<tr>
<td>o The Participant Manual is the basic reference document for this training.</td>
</tr>
<tr>
<td>o The Participant Manual includes a set of class note pages for every session.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>H. Test Your Knowledge (Pre-Test)</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

Conclusion of Session I
### 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>
<th>Learning Activities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. National Drug Statistics</td>
<td>o Instructor Led Presentations</td>
</tr>
<tr>
<td>B. State and Local Drug Use</td>
<td></td>
</tr>
<tr>
<td>C. Drugs and the Internet</td>
<td></td>
</tr>
<tr>
<td>D. Development of the DITEP Training Program</td>
<td></td>
</tr>
<tr>
<td>E. National Drug Statistics</td>
<td></td>
</tr>
<tr>
<td>F. State and Local Drug Use</td>
<td></td>
</tr>
<tr>
<td>G. Drugs and the Internet</td>
<td></td>
</tr>
<tr>
<td>H. Development of the DITEP Training Program</td>
<td></td>
</tr>
</tbody>
</table>
A. National Statistics

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.
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.

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.
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.

Motor vehicle crashes remains the number one cause for teenage 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)
B. State and Local Drug Use

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.

“There is no guarantee that the next generation will learn the lesson,” (Source: Monitoring the Future, 2019).

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.

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.

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.

**Conclusion of Session II**
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.

<table>
<thead>
<tr>
<th>Content Segments:</th>
<th>Learning Activities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Physiology of Alcohol</td>
<td>o  Instructor Led Presentations</td>
</tr>
<tr>
<td>B. Types of Alcohol</td>
<td></td>
</tr>
<tr>
<td>C. Physiological Process</td>
<td></td>
</tr>
<tr>
<td>D. Elimination</td>
<td></td>
</tr>
<tr>
<td>E. Dose/Response Relationships</td>
<td></td>
</tr>
</tbody>
</table>

Session III
Overview of Alcohol
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 microbrewed 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.

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

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.

### D. Absorption

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.
### 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.

**Parts of the body that have lots of water include:**

- Brain
- Liver
- Muscle tissue
- Kidneys

**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.

- 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.

### 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.

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.

The metabolism of alcohol consists of a slow controlled burning of the alcohol.

The speed that the liver metabolizes alcohol varies from person to person and may periodically change for any person.

The average rate of metabolism is 0.015% per hour.
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.

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

Conclusion of 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.

<table>
<thead>
<tr>
<th>Content Segments:</th>
<th>Learning Activities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Definition of “Drug”</td>
<td>o  Instructor Led Presentations</td>
</tr>
<tr>
<td>B. Seven Drug Categories</td>
<td></td>
</tr>
<tr>
<td>C. Drug Combinations</td>
<td></td>
</tr>
</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”

- 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.”
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.
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)
- 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

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.

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

- Pupil size will usually be normal.

General Indicators of CNS Depressant Impairment:

- Drowsy acting
- Thick, slurred speech
- Uncoordinated, fumbling fingers
- Flaccid muscle tone
- Sluggish acting
- Droopy eyelids
- Bloodshot, watery eyes
- Slowed reflexes
- Poor balance and coordination
- Drunk-like behavior
### 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

### 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.
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 that has been 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.
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.
### 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).

#### 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

Typical Methods of Ingestion:

- Oral
- Smoking
- Snorting
- Injecting
### Duration of Effects:

<table>
<thead>
<tr>
<th>Substance</th>
<th>Onset</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cocaine (Powder - Snorted)</td>
<td>Immediate</td>
<td>45 to 90 mins</td>
</tr>
<tr>
<td>Cocaine (Crack – Smoked)</td>
<td>Immediate</td>
<td>5 to 10 mins</td>
</tr>
<tr>
<td>Amphetamine (Oral, pill form)</td>
<td>30 to 40 secs</td>
<td>4 to 8 hours</td>
</tr>
<tr>
<td>Methamphetamine (Crank or Speed – Snorted, Injected or Oral)</td>
<td>30 to 40 secs</td>
<td>Up to 12 hours</td>
</tr>
</tbody>
</table>

### Possible CNS Stimulant Overdose Symptoms:
- Dramatic increase in heart rate
- Hallucinations
- Psychosis
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.
• **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.
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 potant as LSD. Street names include heavenly blue, flying saucers, and pearly gates.

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

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
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.

- 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.

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.

## 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

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
**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.

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.

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:
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.

- **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.

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

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
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: 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 audible popping sound.
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
- 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

General Indicators
- Odor of inhaled substance
- Dizziness, numbness
- Traces of substance around the face and nose
- Bloodshot, watery eyes
- Distorted perception, time and space

More General Indicators
- Inebriation similar to alcohol intoxication
- May complain of 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”)
    - Nitrous Oxide: 5 minutes or less
    - Volatile solvents: Several hours (gasoline, paint)
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)

People under the influence of Cannabis are typically relaxed, care-free acting and will exhibit divided attention impairment.
## Expected Results of Observations/Indicators of Impairment:

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

### Eye Indicators:
- No nystagmus
- Pupil size will be dilated, but may be normal

### General Indicators:
- Odor of marijuana
- Relaxed inhibitions
- Marked reddening of the eyes
- Body tremors
- Disorientation
- Attention difficulties
- Impaired perception of time and distance
- Marijuana debris in the mouth
- Eyelid tremors
- Increased appetite

### Other Conditions That May Mimic Cannabis Impairment Symptoms:
- Some medical conditions can be associated with a lack of attention. An example would be attention deficit hyperactivity disorder (ADHD).

### Possible Overdose Symptoms:
- Acute anxiety attacks
- Paranoia
- Possible psychosis
- 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
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).
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.

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.
Conclusion of Session IV

Questions Regarding Drug Combinations and Drug Symptomology Chart Review
# DITEP Drug Symptomology Chart

<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><strong>GENERAL INDICATORS</strong></td>
<td>Disoriented</td>
<td>Anxiety</td>
<td>Body tremors</td>
<td>Blank stare</td>
<td>Depressed reflexes</td>
<td>Bloodshot eyes</td>
<td>Body tremors</td>
</tr>
<tr>
<td></td>
<td>Drowsiness</td>
<td>Body tremors</td>
<td>Dazed appearance</td>
<td>Chemical odor</td>
<td>Confused</td>
<td>Confused</td>
<td>Drowsiness</td>
</tr>
<tr>
<td></td>
<td>Drunk-like</td>
<td>Euphoric</td>
<td>Difficulty with speech</td>
<td>Disoriented</td>
<td>Disoriented</td>
<td>Drowsiness</td>
<td>Euphoria</td>
</tr>
<tr>
<td></td>
<td>behavior</td>
<td>Talkative</td>
<td>Hallucinations</td>
<td>Hallucinations</td>
<td>Hallucinations</td>
<td>Euphoria</td>
<td>Eyelid</td>
</tr>
<tr>
<td></td>
<td>Impaired</td>
<td>Exaggerated</td>
<td>Impaired perception of time and distance</td>
<td>Incomplete verbal responses</td>
<td>Non-communicative</td>
<td>Non-communicative</td>
<td>Eyelid</td>
</tr>
<tr>
<td></td>
<td>judgment</td>
<td>reflexes</td>
<td>Memory loss</td>
<td>Incomplete verbal responses</td>
<td>Droopy eyelids</td>
<td>Non-communicative</td>
<td>Eyelid</td>
</tr>
<tr>
<td></td>
<td>Relaxed</td>
<td>Excited</td>
<td>Nausea</td>
<td>Non-communicative</td>
<td>Drowsiness</td>
<td>Non-communicative</td>
<td>Eyelid</td>
</tr>
<tr>
<td></td>
<td>inhibitions</td>
<td>Grinding teeth</td>
<td>Paranoia</td>
<td>Non-communicative</td>
<td>Dry mouth</td>
<td>Non-communicative</td>
<td>Eyelid</td>
</tr>
<tr>
<td></td>
<td>Slow, sluggish</td>
<td>Hyperactivity</td>
<td>Perspiring</td>
<td>Psychedelic</td>
<td>Euphoria</td>
<td>Non-communicative</td>
<td>Eyelid</td>
</tr>
<tr>
<td></td>
<td>reactions</td>
<td>Increased</td>
<td>Synesthesia</td>
<td>Psychedelic</td>
<td>Facial itching</td>
<td>Non-communicative</td>
<td>Eyelid</td>
</tr>
<tr>
<td></td>
<td>Thick, slurred</td>
<td>alertness</td>
<td>Uncoordinated</td>
<td>Psychedelic</td>
<td>Nausea</td>
<td>Non-communicative</td>
<td>Eyelid</td>
</tr>
<tr>
<td></td>
<td>speech</td>
<td>Insomnia</td>
<td>Uncoordinated</td>
<td>Psychedelic</td>
<td>“On the nod”</td>
<td>Non-communicative</td>
<td>Eyelid</td>
</tr>
<tr>
<td></td>
<td>Uncordinated</td>
<td>Irritability</td>
<td>Perspiring</td>
<td>Non-communicative</td>
<td>Dry mouth</td>
<td>Non-communicative</td>
<td>Eyelid</td>
</tr>
<tr>
<td></td>
<td>Unsteady walk</td>
<td>Restlessness</td>
<td>Possibly violent</td>
<td>Non-communicative</td>
<td>Euphoria</td>
<td>Non-communicative</td>
<td>Eyelid</td>
</tr>
<tr>
<td></td>
<td>Talkative</td>
<td>Tally</td>
<td>Slow, slurred speech</td>
<td>Non-communicative</td>
<td>Fast speech</td>
<td>Non-communicative</td>
<td>Eyelid</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Slowed responses</td>
<td></td>
<td></td>
<td></td>
<td>Eyelid</td>
</tr>
</tbody>
</table>

| **DURATION OF EFFECTS** | Barbiturates: 1-16 hours | Cocaine: Up to 2 hours | LSD: 6-8 hours | DMX: 3-6 hours | Fentanyl: 2-3 hours | Heroin: 3-5 hours | PCP: 4 – 6 hours | Anesthetic gases and aerosols - very short duration |
|                        | Tramadol: 4-8 hours | Meth: Up to 12 hours | MDMA: 1-3 hours | Ketamine: Up to 2 hours | Inhalation | Inhalation | Inhalation | Inhalation |
|                        |                |                  | Psilocybin: Up to 5 hours |                |                |                |                |                |
|                        |                |                  |                |                |                |                |                |                |

| **USUAL METHODS OF ADMINISTRATION** | Oral | Injected | Injected | Insufflation | Oral | Inhaled | Oral | Inhaled | Oral | Inhaled | Oral |
|                                    |      | Insufflation |                | Transdermal |     |         | Transdermal |         | Transdermal |     |         |
|                                    |      | (snorting) |                | Oral |          | Smoked |                | Smoked |                | Smoked |                |
|                                    |      | (occasionally) |                | Transdermal |     |         | Transdermal |         | Transdermal |     |         |
|                                    |      | Inhaled |                | Oral |          | Smoked |                | Smoked |                | Smoked |                |
|                                    |      | Insufflation |                | Oral |          | Transdermal |         | Transdermal |     |         |
|                                    |      | Oral |                | Smoked |          | Transdermal |         | Transdermal |     |         |
|                                    |      | Smoked |                | Transdermal |     |         | Transdermal |         | Transdermal |     |         |
|                                    |      | Transdermal |                | Oral |          | Transdermal |         | Transdermal |     |         |

| **OVERDOSE SIGNS** | Clammy skin | Coma | Rapid, weak pulse | Shallow breathing | Hallucinations | Psychosis | Violent behavior | Condition similar to heat stroke | Coma | Seizures | Coma | Convulsions | Cardiac arrhythmia | Nausea/vomiting | Respiration ceases | Risk of death | Acute anxiety attacks | Excessive vomiting |
|                        | Coma | Seizures |                   |                   |          |          |                   |                   |          |          |          |                   |                   |                   |                   |                   |                   |                   |
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>o Instructor Led Presentations</td>
</tr>
<tr>
<td>B. What to Do When You Suspect a</td>
<td></td>
</tr>
<tr>
<td>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</td>
<td></td>
</tr>
<tr>
<td>Parents</td>
<td></td>
</tr>
<tr>
<td>I. Words That May Cause a Negative</td>
<td></td>
</tr>
<tr>
<td>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>
A. **Review of School Policy**

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

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.
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.

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.

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.

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.
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

- **School Principals, Deans, Administrators**
  - Take appropriate action consistent with the school’s policies
  - Include all applicable team members
  - Consider the observations of the teacher, counselor, and nurse
  - Consider the welfare and safety of the entire student/staff body
- School Nurses
  - Listen to the teacher’s observations
  - Interview the student.
    - Medical questions.
    - Clinical assessments
  - Document your observations
  - Inform administrators of the situation and present your observations

- Others
  - Emergency medical personnel
  - School Resource Officers (SROs)
  - Security
  - On-Duty law enforcement personnel
**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.

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.

Possession of drugs is a crime.

- Having drugs in your school system may or may not be against the law depending on state laws
- However, driving under the influence of drugs is illegal in every state

### Drug-Free School Zone

<table>
<thead>
<tr>
<th>Drug-Free School Zones</th>
</tr>
</thead>
<tbody>
<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>

United States Federal law and many state and local laws increase penalties for illegal drug-related activities in Drug-Free School Zones.

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.

The issue of school safety is a shared concern. 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.
### 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?

### 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!
- Offer the parent(s) referrals to available resources
Be supportive and aware that parent(s) may deny students use of drugs.

### 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?

**Words Which May Result in a Negative Reaction**

<table>
<thead>
<tr>
<th>Diagnosed</th>
<th>Arrest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs</td>
<td>Out of Control</td>
</tr>
<tr>
<td>High</td>
<td>Crazy</td>
</tr>
<tr>
<td>Drunk</td>
<td>Jail</td>
</tr>
<tr>
<td>Druggie</td>
<td>Others?</td>
</tr>
<tr>
<td>Suspect</td>
<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?**
### 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>
</tbody>
</table>

- **Appendix 6A:** Suggested Additional References and Resources
- **Appendix 6B:** Expected Duration and Detectability of Drugs in Urine
- **Appendix 6C:** Sample Referral Interview Form

![SESSION VI References](image)
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>A. Internet Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Contains specific pages for parents and teachers about drugs of abuse, drug trends, and treatment options.</em></td>
</tr>
<tr>
<td>Erowid - <a href="https://www.erowid.org">https://www.erowid.org</a>.</td>
</tr>
<tr>
<td><em>A pro-drug non-profit educational and harm-reduction resource with information about psychoactive drugs and drug effects.</em></td>
</tr>
<tr>
<td><em>Government site for highway safety information and statistics.</em></td>
</tr>
<tr>
<td><em>Site for legal issues and materials explaining drug assessment procedures in lay terms.</em></td>
</tr>
<tr>
<td><em>A pill identification resource site.</em></td>
</tr>
<tr>
<td><em>A medical-based resource for information about drugs and “herbal” substances.</em></td>
</tr>
<tr>
<td><em>A database maintained by the FDA providing information about various prescription drugs.</em></td>
</tr>
</tbody>
</table>
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

Questions Regarding Drug Resources?

Day 1 Training Conclusion

Questions? Comments? Disagreements?
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
## Appendix B

### 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>
</tbody>
</table>

### Barbiturates

<table>
<thead>
<tr>
<th>Drug</th>
<th>Retention Time Which Detectable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amobarbital (Tuinal)</td>
<td>2-4 days</td>
</tr>
<tr>
<td>Pentobarbital (Fioral)</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>
</tbody>
</table>

### Benzodiazepines

<table>
<thead>
<tr>
<th>Drug</th>
<th>Retention Time Which Detectable</th>
</tr>
</thead>
<tbody>
<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>Chloralazine (Librium)</td>
<td>Up to 30 days</td>
</tr>
</tbody>
</table>

### Cocaine Metabolites

<table>
<thead>
<tr>
<th>Drug</th>
<th>Retention Time Which Detectable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canna (Marijuana)</td>
<td>12-72 hours</td>
</tr>
</tbody>
</table>

#### Cannabis (Marijuana)

<table>
<thead>
<tr>
<th>Use</th>
<th>Retention Time Which Detectable</th>
</tr>
</thead>
<tbody>
<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>
</tbody>
</table>

### Opiates (Narcotic Analgesics)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Retention Time Which Detectable</th>
</tr>
</thead>
<tbody>
<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>
</tbody>
</table>

### PCP (Ketamine)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Retention Time Which Detectable</th>
</tr>
</thead>
<tbody>
<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. **SOURCES:**

Appendix 6C

**REFERRAL FORM:** To be conducted as soon as possible after the student’s assessment.

**Purpose:** To obtain a summary of the student’s behavior that led the staff member to refer the student.

**DITEP ASSESSMENT FORM**

STUDENT NAME: ___________________________ DATE: _________ GRADE: ___ TIME: ____________

REASON FOR REFERRAL: ________________________________________________________________

PERSON MAKING REFERRAL(s): __________________________________ POSITION: ____________

COLLABORATING PERSONNEL(s): __________________________________ POSITION: ____________

ADMINISTRATOR NOTIFIED: ____________________________________________________________

---

**FIRST IMPRESSION – GENERAL APPEARANCE** (Circle all that apply)

GAIT: Steady Weaving Needs assistance to walk Hold/reaching for support Other (Explain) ____________

Comments ________________________________________________________________

CLOTHING: Disheveled Neat Clean Dirty Tattered Coat on/off Arms exposed Hat on

Multiple layers Appropriate for season Odor to clothing (describe) ____________________________

HAIR: Combed Matted or unkempt Clean Dirty Debris in Hair

FACE: Flushed Cyanotic/Pale/Clean Dirty Shaved Unshaven (estimate # days growth) ____________

Bruised Bleeding Piercing - Yes/No Number ___ Location __________________

LIPS: Bruised Burn marks Canker/cold sore/blisters Swelling Chapped/dry

HANDS: Clean Dirty Tremors Clenched fist(s) Hand(s) in pocket(s)

ODOR: Cigarette Marijuana Chemical Vomitus

BODY: Diaphoretic (sweating) Where (forehead, above lip, temples) ____________ Warm to touch

Comments ________________________________________________________________

DEMEANOR: Blank stare Calm Smiling Agitated Frowning/scowling Crying

Slow movements (sluggish) Antagonistic Euphoric Fumbling Grinding teeth Hallucinating

SPEECH: Normal tone Normal speed Clear Garbled Slowed Slurring Yelling Talkative

Comments ________________________________________________________________

**INTRODUCTION STATEMENT**

Explain why they are being assessed, but do not state that you are doing a drug exam. Example, “I am concerned about...” Confirm student understands.

Student Reaction: Verbal Yes / No Nonverbal Yes / No No response Other ____________________________

Appears focused (eye contact) Appears to comprehend Following directions

Comments ________________________________________________________________
PRELIMINARY EXAM/QUESTIONS:
Indicate if there is no reply to questions. Note if speech is clear/garbled etc. Where applicable, note type, time taken and quantity.

Without looking, can you tell me what time it is?________________________ Actual time:________________________

Have you taken any medications today? Recently? Verbal: Yes / No Nonverbal: Yes / No No response
Type___________________________ Time____________________ Quantity________________________

Have you taken any drugs today? Recently? Verbal: Yes / No Nonverbal: Yes / No No response
Type___________________________ Time____________________ Quantity________________________

Have you ingested any alcohol today? Recently? Verbal: Yes / No Nonverbal: Yes / No No response
Type___________________________ Time____________________ Quantity________________________

Have you had any injury to your head today? Recently? Verbal: Yes / No Nonverbal: Yes / No No response

Do you have any allergies?________________________________________________________

When did you last eat?________________________ What did you eat?____________________________________________________

When did you last sleep?________________________ How long did you sleep?________________________

Are you diabetic? Yes / No Do you take insulin? Yes / No Type___________________________ Time____________________

Are you an epileptic? Yes / No Do you take seizure medication? Yes / No

VITAL SIGNS: Time:_____________ Temperature___________________ Pulse_______________ BP______________

Comments______________________________________________________________________________________________

EYES: Do you wear glasses? Yes / No Do you wear contacts? Yes / No Do you have contacts in? Yes / No

Do you have blindness in either eye? Yes / No Have you ever injured your eye? Yes / No Have you ever had eye surgery? Yes / No

EYE EXAMS

LACK OF SMOOTH PURSUIT
Stand in front of the student while giving instructions. Have the student remove their glasses if they are wearing them. Hold the stimulus 12-15” from the face, in front of the nose and slightly above eye level. If the student’s eyelids are droopy, hold the stimulus slightly higher to better view the eyes. Start with the student’s left eye. Use smooth motions from one side to the other.

Give the following instructions: Stand with your feet together and your arms down at your sides. Stay in that position until I tell you the test is finished. I want you to follow the tip of my penlight (stimulus) with your eyes and your eyes only. Do not move your head. Continue to focus on the tip of my penlight until I tell you to stop. Do you understand the instructions?

Check for equal pupil size, resting nystagmus, and equal tracking.

Pupils Equal in Size: Yes / No Resting Nystagmus: Yes / No Equal Tracking: Yes / No

Lack of Smooth Pursuit
Check for lack of smooth pursuit in both eyes. Start at the center (nose). Move the stimulus from your right to your left without stopping. Make two complete passes, taking approximately 4 seconds per pass. Record the requests.

Lack of smooth pursuit: Left eye: Yes / No Right eye: Yes / No Comments:__________________________________________
DISTINCT AND SUSTAINED NYSTAGMUS AT MAXIMUM DEVIATION
After checking for Lack of Smooth pursuit, move the stimulus to your right (student’s left eye) to maximum deviation with no white of the eye showing. Hold the stimulus for a minimum of 4 seconds. Then move the stimulus to your left so the student’s right eye is at maximum deviation. Hold the stimulus for 4 seconds. Repeat the check for both eyes and record the observations.

<table>
<thead>
<tr>
<th>Maximum deviation:</th>
<th>Left eye: Yes / No</th>
<th>Right eye: Yes / No</th>
<th>Comments:</th>
</tr>
</thead>
</table>

ONSET OF NYSTAGMUS PRIOR TO 45 DEGREES
After checking for distinct and sustained nystagmus a maximum deviation, check for an onset of nystagmus prior to 45 degrees. Do so by moving the stimulus to your right slowly until you observe the onset of nystagmus. It should take approximately 4 seconds to reach 45 degrees. At 45 degrees, you should be parallel to the outside of the student’s shoulder. You should see only a slight white crescent in the corner of the eye. If you observe nystagmus prior to 45 degrees stop moving the stimulus at the first onset. Note the angle. Repeat the procedure for the right eye. Repeat the check for both eyes. Note your observations.

<table>
<thead>
<tr>
<th>Estimated angle of onset:</th>
<th>Left eye: _____ degrees</th>
<th>Right eye: _____ degrees</th>
<th>Other observations:</th>
</tr>
</thead>
</table>

VERTICAL GAZE NYSTAGMUS
To check for vertical gaze nystagmus, start in the center of the student’s face and move the stimulus straight up until no white is showing at the top of the eye. Look for the involuntary jerking of the eyes up and down. Hold for a minimum of 4 seconds. Move the stimulus back to the center and repeat the check. Note your observations.

<table>
<thead>
<tr>
<th>Vertical nystagmus present:</th>
<th>Yes / No</th>
<th>Comments:</th>
</tr>
</thead>
</table>

LACK OF CONVERGENCE
Explain the test to the student and make sure they understand to watch the stimulus throughout the test. Start in the center above the student’s eye level and move the stimulus in two large circles around the student’s face, then move the stimulus towards the bridge of the nose. DO NOT TOUCH THE BRIDGE OF THE NOSE. The stimulus should be brought in to within approximately 2” of the nose and held for approximately 1 second. Note if the eyes both move in, one moves in, if they move in and stop halfway, if they move in and then drop down and back out or if the eyes do not converge at all. Note your observations. You may not see the same reaction with both eyes.

<table>
<thead>
<tr>
<th>Able to follow stimulus:</th>
<th>Yes / No</th>
<th>Both eyes: Yes / No</th>
<th>One eye only: Yes / No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Droopy eyelids: Yes / No</th>
<th>Eyes: Watery: Yes / No</th>
<th>Bloodshot eyes: Yes / No</th>
<th>Other: ____________________________</th>
</tr>
</thead>
</table>

Indicate the result using the diagrams below to best show the student’s reaction to the test.

![Diagram](image_url)

DIVIDED ATTENTION TASKS
MODIFIED ROMBERG BALANCE
Stand in front of the student while giving instructions. Demonstrate the test but do not close your eyes. Once the test has begun you may move around the student for better observations. If at any time the student appears they could fall or be injured, stop the test, and record the results and the reason for stopping the test.

Give the following instructions: Stand with your feet together and arms down at your sides. Stay in that position until I tell you to begin. When I tell you to begin, I want you to tilt your head back, close your eyes and estimate when 30 seconds have gone by. When you think 30 seconds have gone by, open your eyes, tilt your head forward and say ‘stop’. Do you understand the instructions?

<table>
<thead>
<tr>
<th>Verbal: Yes / No</th>
<th>Nonverbal: Yes / No</th>
<th>Other: ____________________________</th>
<th>Time estimated (+/-30 seconds) __________________</th>
</tr>
</thead>
</table>

Circle all that apply:  Body tremors  Inability to close eyes completely  Circular or jittery sway  Counting to self

<table>
<thead>
<tr>
<th>Moves feet apart</th>
<th>Not keeping arms at sides</th>
<th>Cannot keep balance during instruction</th>
<th>Eyelid tremors</th>
</tr>
</thead>
</table>

| Counting out loud | Loses balance | Starts too soon | Other: ____________________________ |
Note the approximate distance the student swayed (inches):    Forwards______ Backwards______ Left______ Right______

Comments______________________________________________________________________________________

WALK AND TURN
Stand at an angle at a safe distance from the student while giving the instructions. When the test begins you may move around to better observe the student. **Do not have the student walk towards you.** If it appears the student could fall or become injured, stop the test, and record the reason(s) for stopping the test.

**Give the following instructions:** Put your left foot on the line (if available) with the front of your right foot touching heel to toe. (Demonstrate the heel-to-toe stance). Put your arms down at your sides. Stay in that position until I tell you to begin. When I tell you to begin, I want you to walk 9 heel-to-toe steps up the line. When you get to your 9th step, leave your front foot on the line and turn taking a series of small steps, and return 9 heel-to-toe steps back down the line (Demonstrate the turn). While you are doing this, look at your feet, count your steps out loud, keep your arms down at your sides and once you start, do not stop. Do you understand?

<table>
<thead>
<tr>
<th>Verbal: Yes / No</th>
<th>Nonverbal: Yes / No</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Loses Balance</td>
<td>□ Starts Too Soon</td>
<td>□ Raises Arms</td>
</tr>
<tr>
<td>□ Missed Heel-to-Toe</td>
<td>□ Improper Turn</td>
<td>□ Steps Offline</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Wrong # of Steps</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments______________________________________________________________________________________

ONE LEG STAND
Stand in front of the student while giving the instructions. Demonstrate the test but **always watch the subject.** Once the test has begun you may move around the student for better observations. If it appears the student could fall or become injured, stop the test, and record the reason(s) for stopping the test.

**Give the following instructions:** Stand with your heels and toes together and arms down at your sides. Stay in that position until I tell you to begin. When I tell you to begin, I want you to raise your (right/left) foot off the floor approximately 6 inches and parallel to the floor. I want you to count out loud in the following manner, ‘One thousand one, one thousand two, one thousand three and so on,’ until I tell you to stop. Keep your arms at your sides. Keep your eyes on your elevated foot. Do you understand these instructions?

Indicate answer:        Verbal: Yes / No  Nonverbal: Yes / No  Other:______________________________________________

Check all that apply:    Left  Right
Sways while balancing    [ ]  [ ]
Uses arms to balance     [ ]  [ ]
Hopping                  [ ]  [ ]
Put foot down, indicate # times: ______________________   ______________________

Stop the test for safety reasons if the subject puts the same foot down 3 times. Indicate by a circled number the number at which the student put their foot down, i.e., “one thousand two” “one thousand ten” “one thousand eighteen” “one thousand nine” etc.

Circle all that apply:  Touched 3 times  Test stopped  Body tremors  Looked out, not down  Counted incorrectly

Stopped counting        Used wrong foot  Can not keep balance during instructions  Started too soon

Comments__________________________

Page 4
FINGER TO NOSE TEST
Stand in front of the student while giving the instruction. Demonstrate the test but do not close your eyes. Once the test has begun you may move around the student for better observations. If it appears the student could fall or become injured, stop the test, and record the reason(s) for stopping the test.

Give the following instructions: Stand with your heels and toes together and arms down at your sides. Point your index fingers down with your palms facing forward (Demonstrate). Stay in that position until I tell you to begin the test. When I tell you to begin, I want you to tilt your head back slightly and close your eyes. I am going to give you a series of commands. I am either going to say, ‘left’ or ‘right.’ When I do, I want you to take that index finger, bring it forward out in front of you and then touch the tip of your finger to the tip of your nose. Do not use the pad of your finger. (Demonstrate the tip of the finger and tip of nose). After you touch your nose, I want you to immediately return your hand to your side. Do you understand these instructions?

Indicate answer: Verbal: Yes / No Nonverbal: Yes / No Other________________________________________________

Example:
Draw lines from spot touched to the numbers.
Write “pad” under the number if student used the pad of the finger.
Write “D” under number if student had to be told to put hand down.
Draw “X” over number if done correctly.

Indicate responses:

Circle all that apply: Body tremors Eyelid tremors Starts too soon Inability to close eyes completely
Eyes roll back instead of closed Swaying Used wrong hand Can not keep balance during instructions

Comments____________________________________________________________________________________________________

EYES, MOUTH, NOSE OBSERVATIONS

EYES:
ROOM LIGHT: Explain you are going to check the student’s eyes. Have your penlight and pupillometer ready. Instruct the student to always look at the same focal spot. You are very close and vulnerable to the student, so be aware of possible violent behavior. Have the student remove their glasses if they are wearing them. Contacts do not have to be removed. Always start with the left eye. Hold the pupillometer next to the temple, even with the eye. Observe the pupil and estimate the size.

DARK ROOM EXAMINATION:
Explain you are going to darken the room and check the students’ eyes. Tell the student you will begin the screening within a few seconds after the light has been shut off. Wait approximately 90 seconds for their eyes (and yours) to adjust to darkness. Have your penlight and pupillometer ready. Instruct the student to always look at the same focal spot. Have another person (observer) in the room during the examination. You are very close and vulnerable to the student, so be aware of possible violent behavior. Have the student remove their glasses if they are wearing them. Contacts do not have to be removed. Always start with the left eye. Hold the pupillometer next to the student’s eye. Observe the pupil and estimate the size using the pupilometer. Record the results.

NEAR TOTAL DARKNESS: Instruct student to look at focal spot. Cover penlight with finger, hold light at top of cheek nest to the left eye. Observe the pupil and estimate the size. Record the results.

DIRECT LIGHT: Instruct the student to look at focal spot. Shine light onto the orbit of the eye, just below the lower lashes for a FULL 15 seconds. Look for the reaction to light. Look for rebound dilation and note any size change. Rebound dilation occurs when the pupils dilate and then start increasing in size with the light still illuminating the eye. Note the size estimations using chart on next page.
### Room Light Near Total Darkness Direct Light Reaction to Light (Normal/Slow/None) Rebound Dilation

<table>
<thead>
<tr>
<th></th>
<th>Room Light</th>
<th>Near Total Darkness</th>
<th>Direct Light</th>
<th>Reaction to Light (Normal/Slow/None)</th>
<th>Rebound Dilation</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEFT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Min. ______ Max. ______</td>
</tr>
<tr>
<td>RIGHT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Min. ______ Max. ______</td>
</tr>
</tbody>
</table>

**MOUTH:** With the room darkened, have the student open their mouth. Examine the mouth with your penlight. Circle all that apply:

- Dry mouth
- Excessive saliva
- Tongue pierced
- Tongue burned
- Tongue scabs
- Tongue discolored
- Sores in mouth
- Gums red
- Gums bleeding
- Teeth intact
- Missing teeth
- Poor oral hygiene
- Other

- Odor (describe smell)
- Debris in mouth (tobacco/plant matter, etc.)

**NOSE:** Have the student tilt back their head and inspect the nasal area with penlight. Circle all that apply:

- Red/inflamed
- Running
- Dried blood
- Bleeding
- Scabs
- Residue (as in powder/inhalant)

**MUSCLE TONE:** Circle all that apply:

- Arms: Rigid Flaccid Near normal Other observations

**QUESTIONS AND STATEMENTS:** Check your assessment against the symptomatology chart. If needed, ask more direct questions to the student or seek clarification. **Do not conduct an interrogation.**

- Comments:
- Student Statement/Comments/Questions
- Preliminary Exam Completed at Time: __________________________ Date: __________________________

**DISPOSITION:**

- Parent/Guardian Notified: __________________________ Relationship: __________________________ Time: __________________________

- No contact/no answer __________________________ Message left @ telephone # __________________________ Time: __________________________

- Parent/Guardian coming for student __________________________ Conference with Parent/Guardian __________________________ Time: __________________________

- EMTs (911) contacted: Yes / No If yes, time __________________________

- Referral to Student Substance Counselor: Yes / No If yes, name __________________________

- Referral to police agency: Yes / No If yes, agency and officer __________________________ Time __________________________

- Other referrals: __________________________ Time __________________________

- Additional comments/actions: __________________________

**ASSESSMENT COMPLETED BY: __________________________ DATE: __________________________ TIME: __________________________**

(Signature)
REFERRAL INTERVIEW
To be conducted as soon as possible after the student’s evaluation.

Purpose: The purpose of the interview of the referring staff member is to obtain a summary of the student’s behavior that led the staff member to refer the student.

Location: ___________________________ Date: ________________ Time: ________________

Name of person filling out referral interview: _______________________________ Position: __________________

What initially attracted your attention to this student? Describe (Be specific) ____________________________________________

Where were you when you observed this student? (In classroom, classroom doorway, hallway, stairwell, etc.,) _______________________________________________________

Where was the student when you noticed him/her? _______________________________________________________

How was the student dressed? Yes / No If yes, describe _______________________________________________________

Was the student carrying anything? _______________________________________________________

If with other students, list names or give descriptions: _______________________________________________________

Did you observe the student eating, drinking, inhaling any substance or smoking? Yes / No __________________

What actions did you observe? _______________________________________________________

Was there an incident or accident? Yes / No Describe _______________________________________________________

Was there a traffic crash? If so, were there any injuries? _______________________________________________________

What did you initially say to the student? _______________________________________________________

What was the student’s response/(note verbal as well as gestures) _______________________________________________________

Did the student attempt to throw away or conceal any items or materials? Yes / No __________________

What is your opinion of the student’s attitude and demeanor during the interaction with you? _______________________________________________________

Did the student complain of illness or injury? If yes, describe _______________________________________________________

Did the student use any “street terms” or slang associated with drugs or drug paraphernalia? If yes, describe _______________________________________________________

How did the student respond to your inquiries? Be specific. _______________________________________________________

Page 1
Did the student’s speech appear to be slurred, slow, rapid, thick, mumbled, etc.? Yes / No If yes, describe ________________________________________________________________

Did you perceive the student as able to focus on your inquiries? Yes / No ____________________________

Was eye contact made? Yes / No Comments __________________________________________________________

Did you touch or direct the student? Yes / No If yes, describe ___________________________________________

Did you smell any unusual odors emanating from the student? Yes / No If yes, describe ______________________

Did the student make or continue any comments after you summoned assistance? Yes / No If yes, describe ____________________________________________________________

What did the student do after you called for assistance? (Remain seated, become agitated, etc.) ______________________

Did the student go with you in a cooperative or hostile manner when instructed to leave the classroom, hallway, etc.? Yes / No Describe __________________________________________________________

**PHYSICAL EVIDENCE:**

What items or materials were found? _________________________________________________________________

Where were items or materials found? _________________________________________________________________

Was any smoking paraphernalia found? Yes / No If yes, describe ___________________________________________

Where were injection materials, i.e., needles, syringes, leather straps, rubber tubes, spoons, bottle caps, etc. found? ________________________________

Was the student’s locker checked? Yes / No If yes, describe _____________________________________________

By whom: ___________________________ Position: ___________________________

Was the student present? Yes / No Were any other belongings of the student’s checked? (clothing, backpack, coat, gym locker) Yes / No If yes, describe ________________________________________________

By whom: ___________________________ Position: ___________________________

What items were found? ____________________________________________________________

Disposition of articles found _______________________________________________________________________

Were articles given to the police? Yes / No If yes, who and when ________________________________

**ADDITIONAL COMMENTS:** ____________________________________________________________________________

______________________________________________________

____________________ Signature _____________________________ Position _____________________________

Page 2