Employer Drug Impairment Training (EDIT)

Instructor Guide

International Association of Chiefs of Police (IACP)

August 2022

A. Purpose of this Training

The purpose of this training is to provide workplace employers and supervisors with a systematic approach to recognizing and evaluating individuals in the work environment who are using and may be impaired by drugs, to provide early intervention and promote workplace safety.

This training is not intended to qualify participants as experts in drug impairment detection but rather its purpose is to aid in the evaluation and documentation of those suspected of using drugs and those impaired bydrugs. For this training, the definition of a drug is *any substance that alters perception or behavior reducing that individual's ability to function appropriately in the work environment.*

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

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

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

> **THIS TRAINING WILL *NOT* QUALIFY A PARTICIPANT TO SERVE AS A DRUG RECOGNITION EXPERT (DRE).**

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

B. Overview of the Training

1. For whom is the training intended?

   This training is designed primarily for administrative staff, supervisors, and employees in the work setting. The participant who attends and completes the training will have a working understanding of indicators of drug impairment and some conditions that may mimic it.

2. What are the purposes of the training?

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

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

   The participant who successfully completes the training will be able to identify

   - The term drug used in the context of this course;
   - The concept of drugs that impair in the work environment;
   - The drugs of choice within a community setting;
   - The observable effects of each of the major drug categories;
   - The effects likely to result from various drug combinations;
   - The importance of policies and procedures for dealing with drug-impaired individuals in the work setting;
   - Medical conditions and other situations that can produce similar signs of impairment; and
   - Appropriate procedures for dealing with drug-impaired or medically impaired individuals.

4. What subject matter does the training over?

   The principal content topics include the following:

(1) The concept of drugs in the work environment.

(2) Basically, as far as the employer is concerned, a drug is a substance that impairs an individual's ability to function appropriately in the work environment.

(3) The magnitude and scope of drug use and abuse in our work environment and the involvement of drugs in impaired incidents.

(4) The observable effects of each of the major drug categories.

(5) The effects likely to result from various drug combinations.

(6) The individual employer's prescribed procedures for dealing with individuals suspected of drug influence or medical conditions.

5. What activities take place during the training?

   The program relies primarily on instructor-led presentations.

6. How long does the training take?

   The training is intended as a 6 to 8 hour training day, including breaks and lunch.

   Course administrators are encouraged to provide certificates of attendance.

   A normal schedule calls for the training to run with a class beginning at 8:00 AM and concluding at 5:00 PM each day. A one-hour lunch period and breaks of fifteen minutes are accommodated in the schedule. It is not intended that the schedule be without flexibility. ***The course administrator is allowed the flexibility to adjust the schedule based on the needs of the participants and/or instructors. In any case, it is required that a class roster be completed.***

C. Overview of the Curriculum Package

In addition to the Administrator's Guide, the curriculum package for this training includes the following material:

- Instructor Guide
- PowerPoint Presentations
- Participant Manual

1. Instructor Lesson Plans Guide

The Instructor Guide is a complete and detailed blueprint of what the course covers and of how it is to be taught. It is organized into 5 sessions, each corresponding to one of the course's sessions.

Each session consists of an outline page and the lesson plans.

The outline page lists present the session's title, the total instructional time suggested to complete the session, the specific learning objectives of the session; that is, what the participants will be able to do once they have successfully completed the session's learning activities. The outline page also lists the session's major content segments and the principal types of learning activities that take place during the session.

The lesson plans themselves are arranged in the following format:

- The training aids (time frames, visual aids, etc.);
- The content of what is to be taught;
- The notes to the instructor that provide guidance concerning how the content is to be taught. They specify, for example, how the instructor is to present the material, involve the participants in the presentation, oversee their practice and ensure that they assimilate the material. Instructor Notes are bold text within boxes in the Instructor Guide.

Typical entries in the Instructor Notes may contain:

- The approximate amount of time to be devoted to each segment;
- Indications of points requiring special emphasis;
- Personal notes;
- Questions that can be posed to the participants to involve them more actively in the training; and
- Examples and other techniques for clarifying the concepts being presented

The Instructor Guide serves as a means of preparing the instructor to teach the course. Every instructor should review the entire set of lesson plans to become familiar with the content and learning activities and develop a clear understanding of how the course fits together. Instructors are expected to become thoroughly familiar with every session they are assigned to teach, to assemble all props and other instructional equipment referenced in the lesson plans, and to augment the instructional notes as necessary to ensure that individual teaching styles and experiences are applied to the content and learning activities.

The Instructor Guide serves as an in-class reference document for helping to maintain the sequence and pace of presentations and other learning activities; however, ***the information contained in the outlines is not to be read verbatim to the participants***. The Participant Manual is contained within the Instructor Guide, but the Participant Manual does not include any Instructor Notes.

2. Visual Aids

Types of visual aids that can be used in this training:

- Dry-Erase board/flip-chart presentations (which are indicated in the instructional notes of the lesson plans, and are self-explanatory);
- Computer presentations (PowerPoint)
- Video presentations are recommended for use. Because of legal use of the videos, they cannot be embedded into the PowerPoint slides, but can be accessed using the internet link in the slides.

The visuals are simple displays of graphic and/or narrative material that emphasize key points and support the instructor's presentation.

Each visual is numbered and is referenced by slide image in the lesson plans to indicate when the visual is to be used.

3. Participant Manual

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

The participant manual will be useful for previewing the sessions, and for studying the subject matter for in preparation for the final examination. The manual will be of greatest use *after* the formal instruction ends and the newly acquired information is utilized.

D. General Administrative Requirements

1. Delivery Contexts

   This training is compatible with a wide variety of delivery contexts. It is designed as a stand-alone training to provide participants with the information needed to recognize and evaluate individuals in the work environment who are using and impaired by drugs, to provide early intervention.

2. Facility Requirements

   The training requires a standard classroom, equipped with a screen, dry-erase board, appropriate projector, audio speakers for showing videos, monitor and adequate seating/table space for all participants.

3. Instructor Qualifications

   The instructor(s) for this training should be a state certified Drug Recognition Expert (DRE) or a DRE Emeritus with experience as a DRE instructor. ***Instructors must be endorsed by the DRE's DEC Program state coordinator or an IACP/DRE regional coordinator if there is no state coordinator.***

Instructors must be completely familiar with the EDIT subject matter.

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

An EDIT Instructor Log is in the Administrators Guide for use. State Coordinators should consider maintaining a file of active EDIT instructors.

4. Class Size Considerations

   The method of instruction is designed to accommodate a reasonably large class.

Instructors should limit the class size based on their ability to allow participants sufficient opportunity to interact with instructors.

E. Planning and Preparation Requirements

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

Select only qualified instructors and assign them to deliver specific segments of the training. Make sure that all instructors review ***all*** portions of the training so that they understand how their assignments fit into the overall course.

Prepare necessary visuals as needed.

Obtain necessary instructional equipment. Ensure equipment is working properly.

Check to see if Internet is available, as it will be needed to access the videos referenced in some of the PowerPoint slides.

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

Obtain (or reproduce) sufficient copies of the Participant Manual

F. Follow-Up Requirements

It is important that both the delivery and impact of this training be evaluated. Evaluation focuses on the general question, what did the participants think of this training? How can the training reduce drug impairment in the workplace?

Important information for evaluating training delivery can be obtained from the anonymous Participant's Critique Form (included in the Instructor Guide). Each participant should be requested to complete and submit the form immediately upon conclusion of the training. Guidelines for analyzing the Participants Critique Form and preparing a post-course evaluation report are covered in Section G.

An accurate record of the overall impact of this training will require keeping records of each assessment completed by those who have attended the EDIT training. The Administrator's Guide provides a copy of a data collection form for recording a minimum of information. The intent of the data collection is to determine effectiveness of training and not to identify any entity in the collection efforts.

DEC Program State coordinators should be notified of each presentation to ensure that proper data is collected and recorded. The appendix to this guide contains sample forms of recommended information to be collected.

G. Guidelines for Preparing Post-Course Evaluation

During the final session of instruction of this course, each participant is expected to complete the anonymous participant's critique form. Many state DEC Program coordinators compile the information obtained from the critiques into a summary report.

A participant's critique form is provided to document participant's initial rating of course content and activities.

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

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

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

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

H. Requests for Information, Assistance or Materials

Formal requests for this training or agencies interested in hosting or conducting a EDIT training should contact their DEC Program state coordinator, or the state's designated representative.

I. Continuing Education Units for Professionals

Note: Continuing education units may be available for in your state or through the workplace organization.

Employer Drug Impairment Training

(EDIT)

Instructor Log

Name:	DRE Number:
Agency:	Telephone:
Address:	Fax:
	E-mail:
	Cell:
DRE Instructor Certified: Yes_____No_____	Other Instructor Certifications:
SFST Instructor Certified: Yes_____No_____	

Date Completed EDIT Trainer Instruction	Hours of Training	Location of Training Class	Lead Instructor	DRE Number

Miscellaneous Instructor Comments *(optional)*

State Drug Evaluation and Classification Program Coordinator Acknowledgment

By my signature, I acknowledge that the above-named candidate is recognized as an instructor for the Employer Drug Impairment Training course.

State DECP Coordinator Signature:_____

* ***For use by the state coordinator***

Employer Drug Impairment Training

Post Test

Name _____

Employer _____

Date _____

1. The procedure which you should utilize in determining impairment by drugs will consist of a_____and_____process.

2. Define the word "drug" as used in this training.

   _____

   _____

3. What is the most commonly abused Central Nervous System Depressant?

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

4. Other drugs are commonly combined with marijuana.

   True_____ False_____

5. A 12 oz. can of beer, a one oz. shot of whiskey, and a 4 oz. glass of wine all have the same approximate amount of alcohol.

   True_____False _____

6. For a drug to cause impairment, it must have an adverse effect on the _____?

   A. Brain
   B. Liver
   C. Muscle Tissue
   D. Heart

7. Impairment from combining 2 or more drugs is called _____?

   A. Speedballing
   B. Poly-drug
   C. Stacking
   D. Combo-pharmacy

8. Name two pupil sizes other than normal that you may see in a person impaired by drugs.

   A. _____

   B. _____

9. When confronting an employee about his/her suspected drug use, it is best to accuse them of their drug use.

   True_____False _____

10. The best indicators that may signal drug impairment are _____.

    A. Change in behavior
    B. Change in friends/associates
    C. Change in appearance
    D. All the above

Employer Drug Impairment Training

ANSWER KEY

(ANSWERS ARE IN BOLD)

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

2. Define the word drug as used in this training.

   Any substance that alters perception or behavior reducing that individual's ability to function appropriately in the work environment.

3. What is the most commonly abused Central Nervous System Depressant?

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

4. Many other drugs are commonly combined with Marijuana

   True Y False

5. A 12 oz. can of beer, a one oz. shot of whiskey, and a 4 oz. glass of wine all have the same approximate amount of alcohol.

   True Y False_____

6. For a drug to cause impairment, it must have an adverse effect on the _____?

   A. **Brain**
   B. Liver
   C. Muscle Tissue
   D. Heart

7. Impairment from combining 2 or more drugs is called _____?

   A. Speedballing
   B. **Poly-drug**
   C. Stacking
   D. Combo pharmacy

8. Name two pupil sizes other than normal that you may see in a person impaired by drugs.

   A. **Constricted**
   B. **Dilated**

9. When confronting an employee about his/her suspected drug use, it is best to accuse them of their drug use.

   True_____ **False Y**

10. The best indicators that may signal drug impairment are _____.

   A. Change in behavior
   B. Change in friends/associates
   C. Change in appearance
   D. All the above

COURSE CRITIQUE
EMPLOYER DRUG IMPAIRMENT TRAINING

Date _____

Location of Training _____

Program Evaluation

1. The content was what I expected.

   Strongly Agree Agree Neutral Disagree Strongly Disagree

2. The speakers were knowledgeable about the subject.

   Strongly Agree Agree Neutral Disagree Strongly Disagree

3. The visuals could be seen easily.

   Strongly Agree Agree Neutral Disagree Strongly Disagree

4. I had no trouble hearing the speakers.

   Strongly Agree Agree Neutral Disagree Strongly Disagree

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

   Strongly Agree Agree Neutral Disagree Strongly Disagree

Content Evaluation

1. I can identify the seven major categories of substance abuse in the work environment.

   Strongly Agree Agree Neutral Disagree Strongly Disagree

2. I can state indicators consistent with determining impairment of an individual.

   Strongly Agree Agree Neutral Disagree Strongly Disagree

3. I can list observable effects of each of the major categories of drugs and poly-drug combinations.

   Strongly Agree Agree Neutral Disagree Strongly Disagree

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

   Strongly Agree Agree Neutral Disagree Strongly Disagree

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

   _____

   _____

   _____

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

   _____

   _____

   _____

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

   _____

   _____

Please circle one:

I would rate the overall training as:

Excellent Good Average Poor

Instructors

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

Instructor Name	Facilitated an atmosphere conducive to learning	Familiarity with the subject(s) presented	Presented information in a manner which met the needs of all participants	Coaching ability in classroom & practical exercises	Ability to answer questions	Tactfulness in correcting mistakes in practical exercises	Overall rating of the instructor

Please use the below space if you have any additional comments.

Employer Drug Impairment Training
Class Roster

Date: **Location of Training**:

Name	Title	Employer

Lead Instructor: _____

Course Administrator: _____

Employer Drug Impairment Training

Teaching Assignments and Itinerary

0800 - 0830 Session I - Introduction and Overview _____

0830 - 0900 Session II - Drugs in Society _____

0900 - 1000 Session III - Overview of Alcohol _____

1000 - 1015 Break

1015 - 1200 Session IV - Drug Identification, Categories & Their Effects

Sections A - C - Definition of Drug: _____

Section D - CNS Depressants: _____

Section E - CNS Stimulants: _____

Section F - Hallucinogens: _____

Section G - Dissociative Anesthetics: _____

Section H - Narcotic Analgesics: _____

1200 - 1300 Lunch

1300 - 1430

Section I - Inhalants: _____

Section J - Cannabis: _____

Section K - Poly-Drugs: _____

1430 - 1445 Break

1445 – 1515 Session V – Policies and Procedures _____

1515 – 1615 Session VI – References _____

1615– 1700 Questions - Discussion (Critiques)
Post Test - (Optional)

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30 Minutes

Session I INTRODUCTION AND OVERVIEW

Overview

Objectives

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

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

Content Segments

A. Welcoming Remarks and Goals

B. Keeping Our Workplace Safe from Drug Impaired Individuals

C. Recognizing Drugs That Impair and Making Referrals

D. Introductions

- Introduction of representatives of host organization and other dignitaries
- Instructor introductions
- Participant introductions

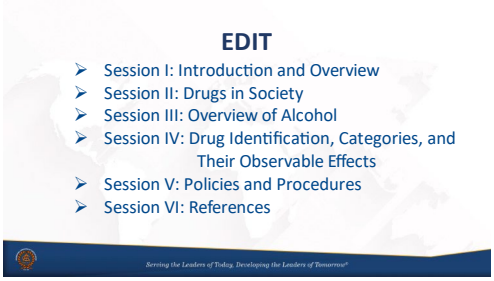
Learning Activities

Instructor Led Presentations

Note: Have participants introduce themselves. If the class is too large for introductions, ask the participants to identify whether they are employers, supervisors, or others.

E. Overview of Course Content

F. Overview of Participant Manual



Note: Go through and explain the Participant Manual to participants. Stress the importance of using the note pages at the end of the sessions.

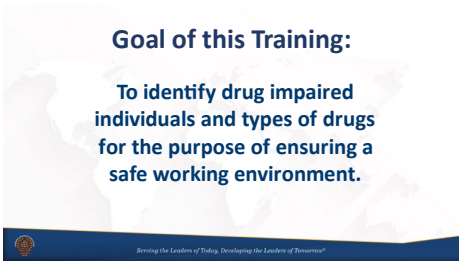
- The Participant Manual is the basic reference document for this training
- The Participant Manual includes a set of class note pages for every session

H. Administrative Matters (as warranted)
- Restroom locations
- Lunch locations/plans
- Parking
- Cellular phones on silent (return calls can be made at the breaks)

SESSION ONE: GOALS AND OVERVIEW

The goal of this training is:

- To identify drug impaired individuals and types of drugs for the purpose of ensuring a safe working environment.



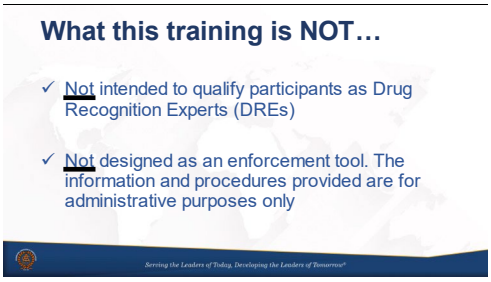
- A secondary goal of this training is to assist in preventing an impaired employee/coworker from driving to and from the workplace or operating equipment or machinery when impaired.

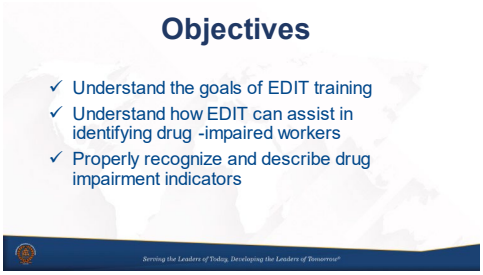
Stress these points: This training is not intended to qualify participants to be drug recognition experts (DREs) but is intended to aid in the evaluation and documentation of possible drug impairment.

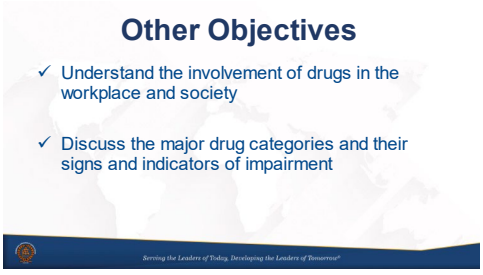
The information and procedures provided are for administrative purposes only and not designed as an enforcement tool. Participants will be doing a lot less than a DRE would do in an enforcement setting.

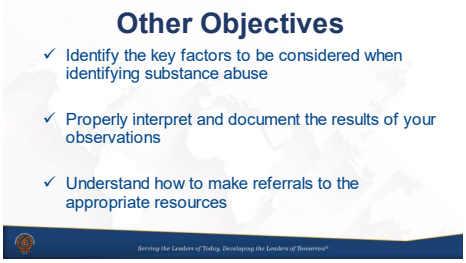
Objectives

- Understand the goals of EDIT training
- Understand how EDIT can assist in identifying drug-impaired co-workers
- Properly recognize and describe drug impairment indicators
- Understand the involvement of drugs in the workplace and society
- Discuss the seven drug categories and their
  signs and indicators of impairment
- Identify the key factors to be considered when identifying substance abuse
- Properly interpret and document the results of your observations
- Understand how to make referrals to the appropriate resources





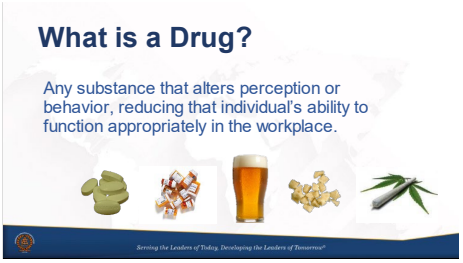




What is a drug?

Solicit various responses from participants on what they think a definition of drug is before showing the course definition in the slide.

<u>The definition of a drug used in this training is</u>:
Any substance that alters perception or behavior reducing that individual's ability to function appropriately in the workplace.



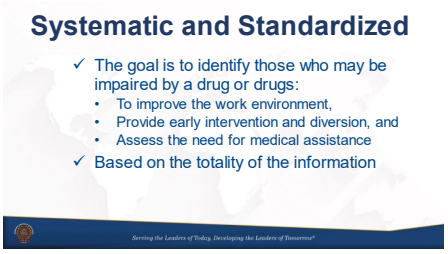
We can do something to keep our workplace safe from drug-impaired individuals.

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

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 proper referrals utilizing the appropriate resources.

Educationally Oriented, Systematic and Standardized Procedure



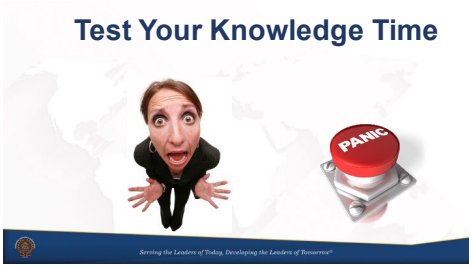
It is important to remember that the EDIT process of identifying suspected impaired individuals is an educationally-oriented, SYSTEMATIC and ATANDARDIZED procedure.

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

Goals include identifying those who may be impaired by a drug or drugs to 1) improve the work 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 observations and should not be based on any one element alone. All assessments must be done SYSTEMATICALLY and COMPLETELY in every instance except for medical emergencies.

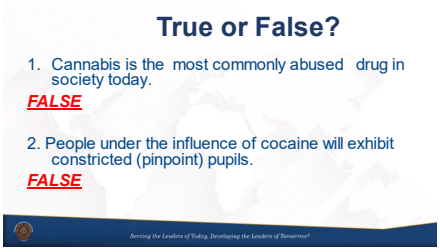
Test Your Knowledge (Pre-Test)

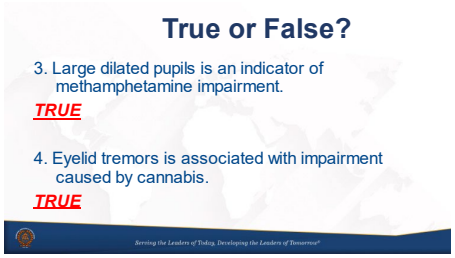


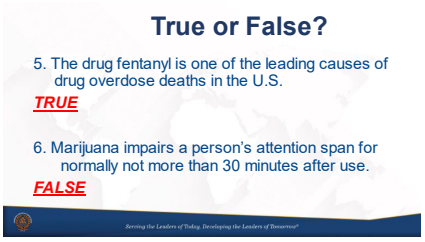
Note: If Continuing Education Unit (CEU) credits are available, explain procedure and provide forms.

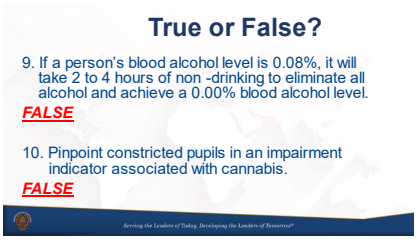
Option 1: A written quiz is available. Participants can grade their own test or trade with the person next to them. At the completion of the training, there may be a final knowledge exam. Review with the class the reason necessary for the post test and the passing requirements.

Option 2: A PowerPoint quiz is built into the presentation package and can be used as the Test Your Knowledge exam (Pre-Test)









30 Minutes

Session II DRUGS IN SOCIETY

Overview

Objectives

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

1. Understand current drug trends and drug usage.
2. Understand why and how the EDIT training was developed.

Content Segments

A. National Drug Statistics

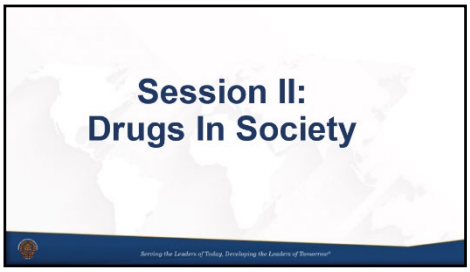
B. State/Local Drug Statistics

C. Drug Trends

D. Development of the EDIT training program

Learning Activities

Instructor Led Presentations

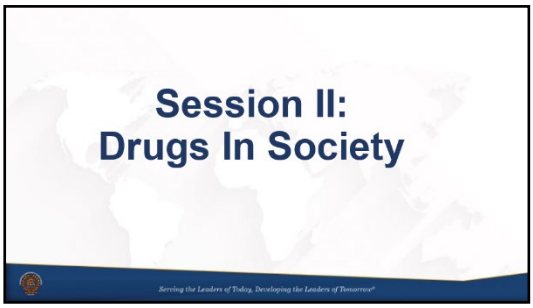


SESSION TWO: DRUGS IN SOCIETY

A. National Statistics:

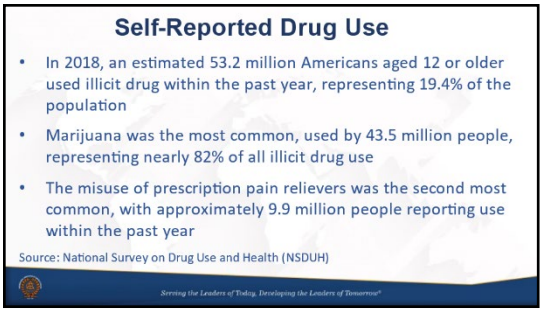
NOTE: For annual updates, go to www.monitoringthefuture.org or www.decp.org

According to the National Institute of Drug Abuse, 52 million Americans aged 12 and older reported using a prescription drug outside of its intended use in the month before the survey was conducted.



The United States holds 5% of the world's population but is responsible for approximately 75% of the world's prescription drug use.

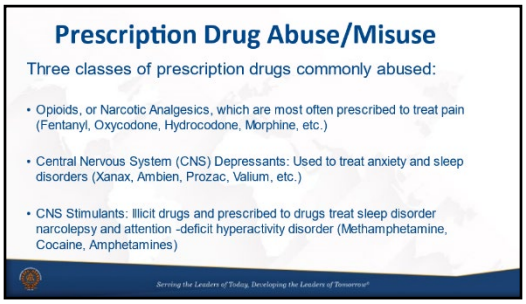
According to the Substance Abuse and Mental Health Services Administrations (SAMHSA) 2018 "*National Survey on Drug Use and Health, 53.2* million people aged 12 or over, used an illicit drug in the past years, which equates to about 1 in 5 Americans. Marijuana was the most common, accounting for nearly 82% of the national illicit drug use. The second most common was the misuse of prescription pain relievers with approximately 9.9 million people reporting use within the past year.



Remind participants that the numbers are very conservative due to self-reporting

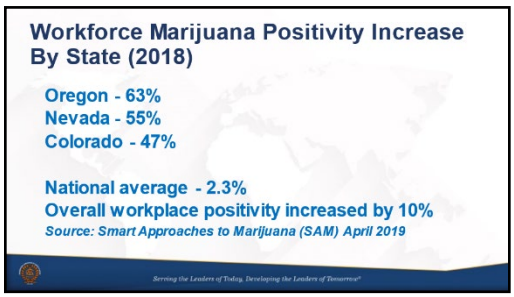
Source: 2018 National Survey on Drug Use and Health Substance Abuse of Mental Health Services Administration (SAMHSA)

Three classes of prescription drugs commonly abused:



- Opioids, or Narcotic Analgesics, which are most often prescribed to treat pain (Fentanyl, Oxycodone, Hydrocodone, Morphine, etc.)
- Central Nervous System (CNS) Depressants: Used to treat anxiety and sleep disorders (Xanax, Ambien, Prozac, Valium, etc.)

- CNS Stimulants: Illicit drugs and prescribed drugs to treat the sleep disorder narcolepsy and attention-deficit hyperactivity disorder (Methamphetamine, Cocaine, Amphetamine)



Illicit Drugs:

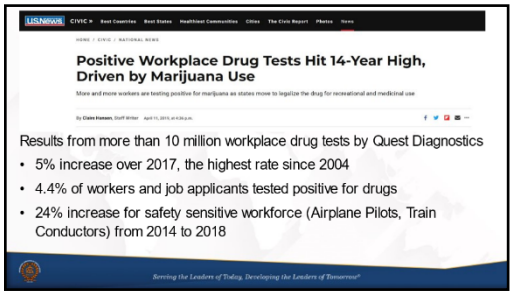
- Cocaine: In 2018 it was estimated that 5.5 million Americans age 12 and up used cocaine in the past year

- During the same period, approximately 5.1 million Americans reported illicit use of prescription stimulants
- An estimated 808,000 people reported using heroin in 2018, nearly double the reported use in 2014

Source: 2018 National Survey on Drug Use and Health Substance Abuse of Mental Health Services Administration (SAMHSA)

Drugs and the Workplace

- Positive Workplace Drug testing hits 14 year high, Driven by Marijuana use. Results form more than 10 million workplace drug tests by Quest Diagnostics show a 5% increase in positive results over 2017. This is the highest rate since 2004



- 4.4% of workers and job applicants tested positive for drugs
- There was a 24% increase for safety sensitive workforce (Airplane Pilots, Law Enforcement, Train Conductors) from 2014 to 2018

Source: Quest Diagnostics

If internet is available, access the link provided in the slide to show 2:25 minute video entitled, "Drugs and Alcohol in the Workplace". Use the video to generate interaction and discussion with the participants.

Workforce Marijuana Positivity Increase

States that have recreational use marijuana saw significant increases in positive test results for marijuana use. Oregon saw a 63% increase; Nevada had a 55% increase and Colorado had a 47% increase. The national average was 2.3% and the overall workplace positivity increase was 10%.

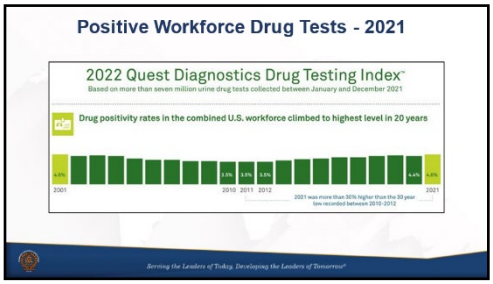
Source: Smart Approaches to Marijuana (SAM) April 2019

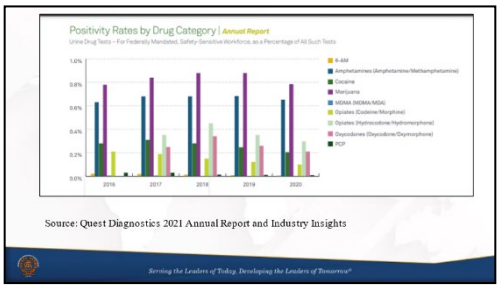
Positive Drug Tests in the Workplace and Drugs Most Often Detected

- According to Quest Diagnostics, drug positivity rates in the workforce climbed to their highest rates in 20 years in 2021

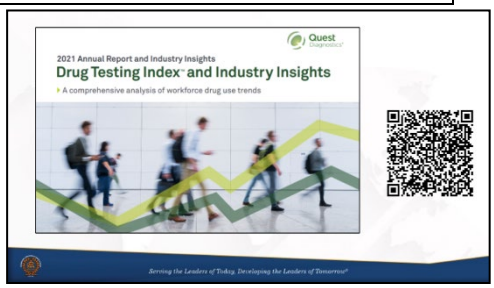
- Quest Diagnostics released results of positive drug tests for 2016 through 2020 in their Annual Report. Although marijuana showed a slight decrease, other drugs remained relatively unchanged or slightly increased.

Source: *Quest Diagnostics, 2021*





Point out the Quest Diagnostics Annual Report and how the participants can access it by using the QR Code in the PPT slide.

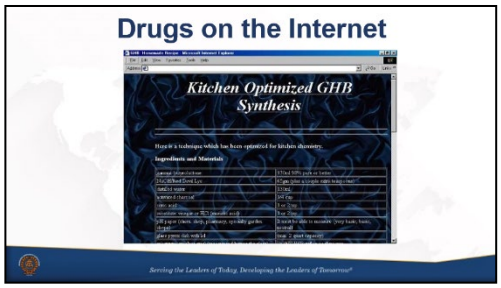


B. State and Local Statistics:

Instructors should obtain state and/or local statistics and discuss local drug trends and issues.

C. Drug Trends:

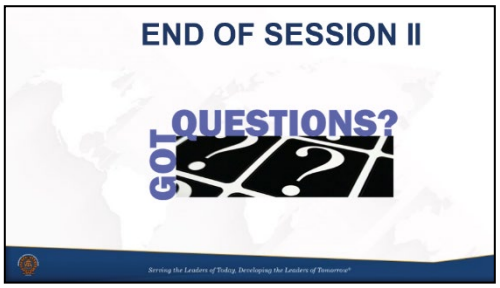
- The instructions for making certain drugs are easily obtained over the Internet. This has added to the increased use, abuse, and popularity of some drugs. Sites like Erowid.com are a good example.



- Certain groups advocate the safe use of drugs by testing for drugs during parties or dance "raves," and give advice on how to take drugs safely to avoid overdosing
- These groups make up what is known as the "harm reduction movement"
- Other social media allows users to share information about drug use and their experiences.

D. Development of the EDIT Training Program

- Increases in drug use, not only in society, but also in the workplace setting lead to the development of this training



- Increase use of drugs in the workplace, both licit and illicit, are a concern in schools, businesses, as well as roadways
- Need for employers to safeguard workplace from drug impaired employees
- Identifying drug-impaired employees and taking proper action can help us avoid drug-impaired drivers on our roadways
- Need to reduce potential lawsuits or civil action due to drug-impaired employees

Solicit additional reasons for this training along with questions from the participants.

30 Minutes

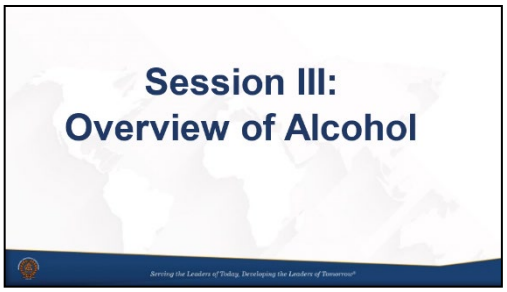
Session III OVERVIEW OF ALCOHOL

Overview

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.

Content Segments	Learning Activities
A. Physiology of Alcohol	Instructor Led Presentations
B. Methyl, Ethyl, and Isopropyl	
C. Physiological Process	
D. Absorption	
E. Distribution	
F. Elimination	
G. Dose/Response Relationships	

Alcohol abuse and misuse remains a major concern in America and throughout the world.

Alcohol is the most widely abused Central Nervous System (CNS) Depressant.

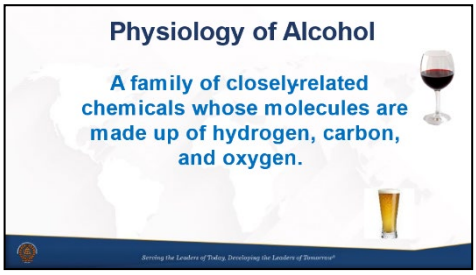
To understand the impact of alcohol, it is important to take a closer look at alcohol, and its effects on the body.

A. Physiology of Alcohol

The word “Alcohol” refers to several distinct, but similar, chemicals.

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

Only one, Ethanol, can be tolerated by the human body in substantial quantities.



B. Methyl, Ethyl and Isopropyl

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.

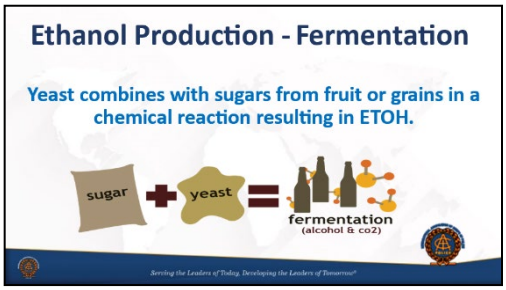
Ethanol is a naturally occurring drug that is produced in nature through a process called fermentation.

In fermentation, spores of yeast, carried by the wind, come in contact with fruit or grain that has fallen to the ground.

Point out: Humans almost certainly encountered this accidentally.

- Sugar in the fruit or grain chemically reacts with the yeast, and produces alcohol

- Today, most fermentation takes place on purpose 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 to 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.

Through the years, people have developed standard-size servings of different alcoholic beverages.

- Beer is usually served in 12-ounce bottles or cans. Beer averages an ethanol concentration of 5%. A can or bottle contains a bit more than one-half ounce of pure ethanol
- Typically, a five-ounce glass of wine has the ethanol concentration of 12%. A glass of wine has just a bit more than one-half ounce of pure ethanol

Point out: Normal bar/restaurant servings of wine are six to ten ounces

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

Point out: Typical bar/restaurants serve one to two shots per drink, with some drinks, such as “Long Island Ice Tea,” containing as much as five ounces of alcohol per drink.

Whiskey usually has an ethanol concentration of 40 percent. A shot of whiskey typically has just a bit more than one-half ounce of pure ethanol.

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

For all practical purposes, standard-size servings of beer, wine and whiskey all pack the same "punch."

C. Physiological Process

Alcohol is a Central Nervous System (CNS) Depressant.

- 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

If internet is available, access the link provided in the slide to show video entitled, "How Does Alcohol Make You Drunk". Use the video to generate interaction and discussion with the participants.

Video link: https://video.link/w/OAecc

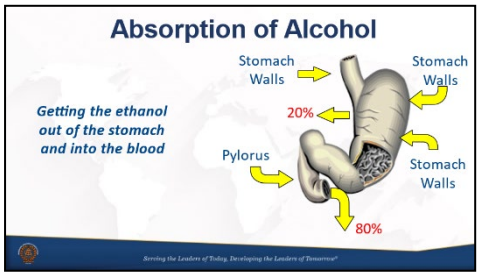
Point out: Alcohol, in addition to drinking it, can be injected, inhaled (fumes) or ingested into the body in a variety of ways.

D. Absorption

Point out: This is a brief overview of the physiology of alcohol.

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

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



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

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

Note: Explain the process of absorption. Explain the pylorus and what its function is.

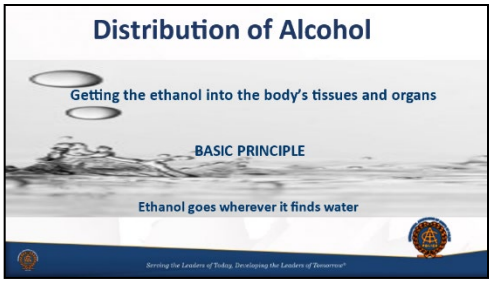
E. Distribution

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

- Alcohol is attracted to water. 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.



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

Parts of the body that have lots of water include:

- Brain
- Liver
- Muscle tissue
- Kidneys

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

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

- Bones
- Fatty tissue

Muscle tissue will receive a relatively high proportion of the alcohol that a person consumes.

Fatty tissue will receive very little of the alcohol consumed.

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

The average male is 68% water. The average female is 55% water – Pose the question as to why this difference exists.

- The female body has more fatty tissue than the male body
- Pound-for-pound, the average female has more fat and less muscle than the average male

Point out: For clarification the female's extra fatty tissue serves as a "shock absorber" and thermal insulator to protect a baby in the womb.

- 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 will be higher than the man's because she has less water in which to distribute the alcohol.

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

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

- Some alcohol is expelled **directly** from the body, i.e., on the breath, in the sweat, in urine, etc.
- The majority of the alcohol consumed is metabolized by the liver

Clarification: Only 2-10% of the alcohol consumed is directly expelled through breath, sweat, tears, urine, etc.

Metabolism of alcohol consists of a slow controlled *burning* of the alcohol.

Note: The liver contains an enzyme called <u>alcohol dehydrogenase</u> which aides in the metabolism of alcohol.

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

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

Pose this question: A person reaches a peak BAC of 0.15%. How long will it take for his or her body to eliminate all of the alcohol?
Answer: Ten hours
0.15% - (x hours) (0.015%)
X = 10

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

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

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

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 person to person.

Reaching blood alcohol concentrations (BAC's) depends upon numerous factors, including:

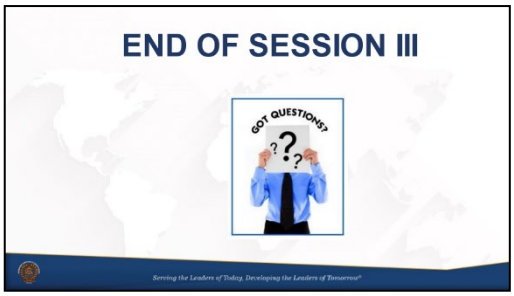
- Man or woman
- Size
- Stomach content
- Time consumed
- Amount consumed
- Health conditions
- Type of alcohol consumed

Pose the question: How much alcohol does it take to get "impaired?"

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

Point out the following example:
A 175-pound man drinks 2 beers or 2 shots in quick succession on an empty stomach, his BAC will climb to slightly above 0.04%. Two more beers will boost him above 0.08%. One more will push him over 0.10%

Solicit questions from the participants.



4 Hours

Session IV

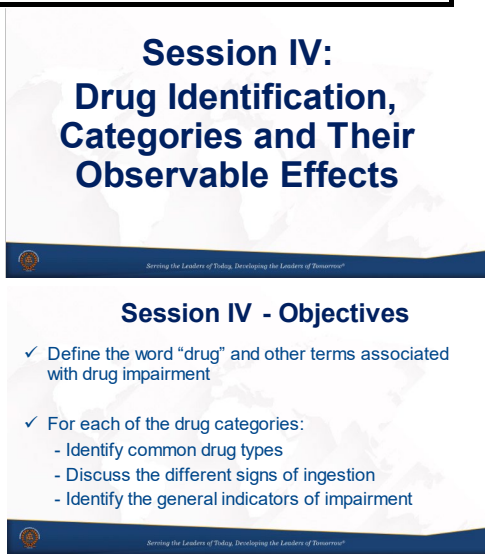
DRUG IDENTIFICATION, CATEGORIES AND THEIR OBSERVABLE EFFECTS

Overview

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 categories of drugs used in this training.
3. Recognize and describe general indicators of impairment of the drug categories.
4. Become familiar with common drugs from the 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. Gain a better understanding of why people abuse drugs.

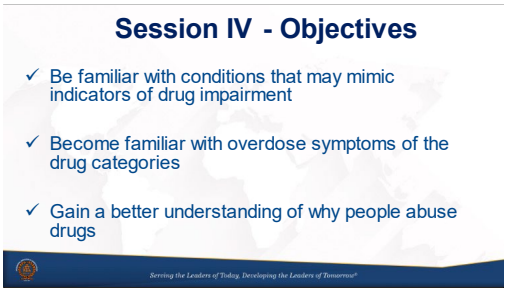


Content Segments

A. Definition of “Drug”
B. Drug Categories
C. CNS Depressants
D. CNS Stimulants
E. Hallucinogens
F. Dissociative Anesthetics

Learning Activities

Instructor-led Presentation



G. Narcotic Analgesics

H. Inhalants

I. Cannabis

J. Drug Combinations

SESSION FOUR: DRUG IDENTIFICATION, CATEGORIES AND THEIR OBSERVABLE EFFECTS

Throughout history, people have used psychoactive substances for a variety of reasons which include altering states of consciousness, reducing pain, forgetting harsh surroundings, altering moods, medicating a mental illness, or enhancing the senses.

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

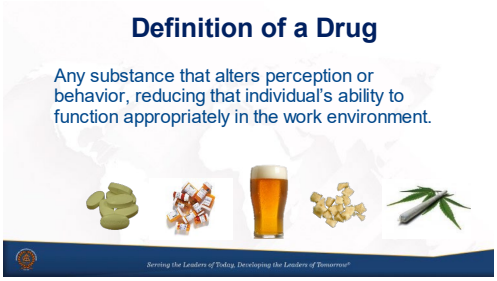
A. Definition of "Drug"

Pose these questions to the participants:

1. Are all drugs medicines? Are all medicines drugs?
2. Are all drugs narcotics?
3. Are all drugs habit-forming substances?
3. 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 work environment."

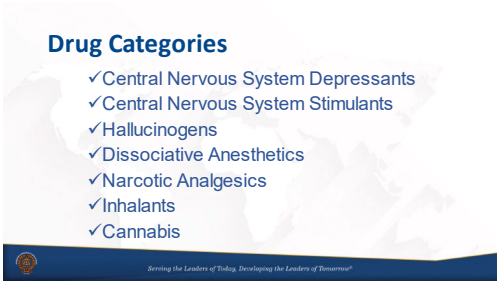


Point out: This definition does not include many substances physicians, chemists, etc. consider to be drugs. It also includes substances not normally thought of as "drugs," such as glue, aerosols, etc.

B. 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 impaired driving training courses there are seven drug categories discussed.



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 a person and type of impairment produced.

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

With training and practice, participants will be able to recognize the signs, symptoms, and the drug category general impairment indicators.

Point out why drugs are placed into categories. Even though drugs within each category may be very different in their makeup, the observable and measurable signs, symptoms, and general indicators produced are similar.

C. 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 of the automatic nervous system, such as, heartbeat, body temperature and breathing will be observable.

The most familiar and abused CNS Depressant is *alcohol.*

Because alcohol is the most often abused impairing substance, it is important to understand just how it works and how it can lead to impairment.

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

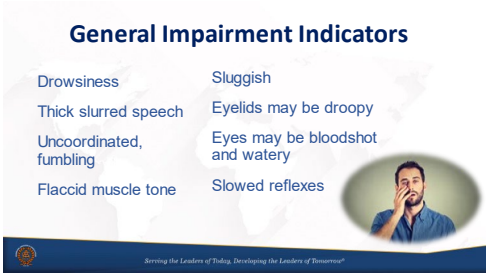
Some popular CNS Depressants other than alcohol include:

- Barbiturates (derivative of barbituric acids) such as, Secobarbital and Phenobarbital
- Anti-anxiety tranquilizers, such as Valium, Librium, and Xanax
- Anti-depressant tranquilizers, such as Prozac and Trazadone
- Anti-psychotics, such as Thorazine, Haldol, and Librium
- Non-barbiturates, such as Quaaludes, Soma, Chloral-hydrate, Gamma-Hydroxybutyrate (GHB), and Kava

In general, people under the influence of CNS Depressants look and act much like people under the influence of alcohol.

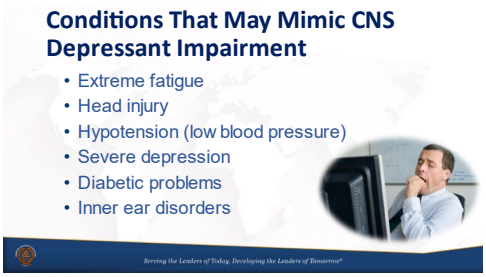
General Indicators of CNS Depressant Impairment:

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



Other Conditions That May Mimic CNS Depressant Indicators:

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



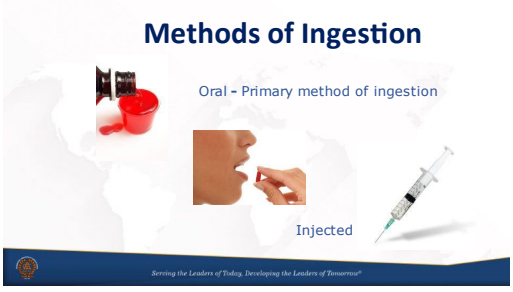
Possible CNS Depressant Overdose Symptoms:

- Shallow breathing
- Cold/clammy skin
- Pupils dilated
- Slow heartbeat

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

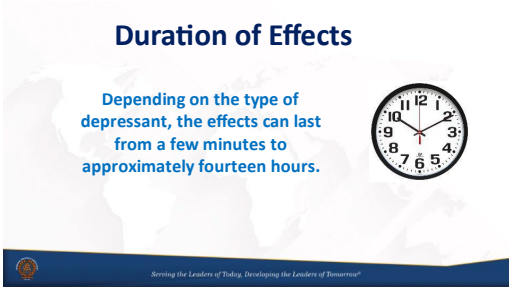
Methods of CNS Depressant Ingestion:

- Oral
- Injected

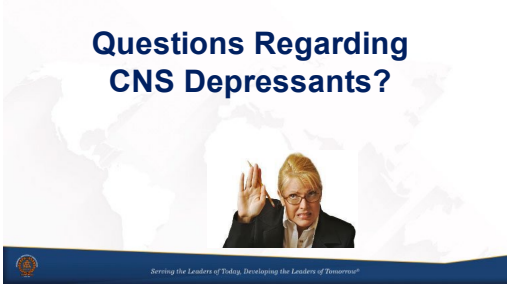


CNS Depressant Duration of Effects:

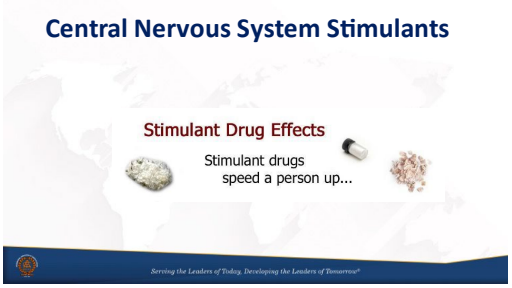
- Depending on the type of depressant, the effects can last from a few minutes to approximately 12-14 hours.



Solicit questions regarding CNS Depressants



D. Central Nervous System (CNS) Stimulants

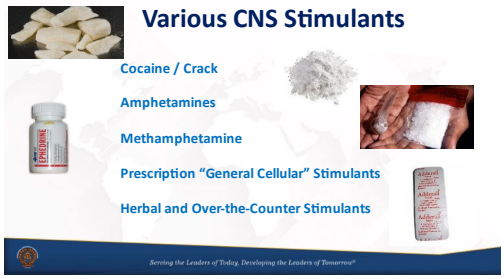


CNS Stimulants accelerate the heart rate and many other processes of the body. For that reason, they have also been referred to as "Uppers."

Although there is a great difference in strength, all stimulants increase the chemical and electrical activity in the CNS. 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 – 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, except for Desoxyn, which is a prescription drug used to treat narcolepsy and attention deficient disorder (ADD) and attention deficit hyperactivity disorder (ADHD).

- Caffeine, Herbal Ecstasy, 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 *Red Bull* ®.

With 80 mg of caffeine, *Red Bull* ® contains more than twice the amount of caffeine found in a 12 ounce can of Coca-Cola ® (35 mg), but less than 8 ounces of brewed coffee. In addition to high levels of caffeine, many energy drinks contain taurine, ginseng, guarana, glucose, and other caffeine-like chemicals.

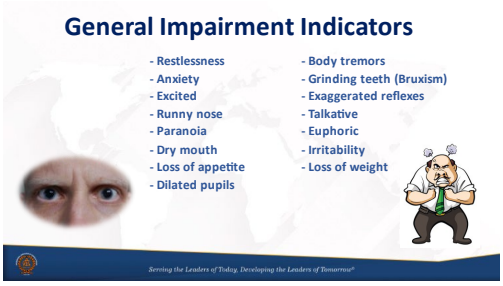
The abuse of energy drinks has been implicated in numerous hospital admissions and impaired driving cases. In large quantities, the effects can mirror the effects of other CNS Stimulants.

Point out: There are many types and brands of energy drinks. Two, Red Bull® and Monster® account for approximately 80% of the energy drink market.

Over-the-Counter (OTC) Stimulants

Legal CNS stimulants are often used to boost performance and are available over the counter (OTC). 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 OTC medications and diet medications.

General Indicators of CNS Stimulant Impairment:

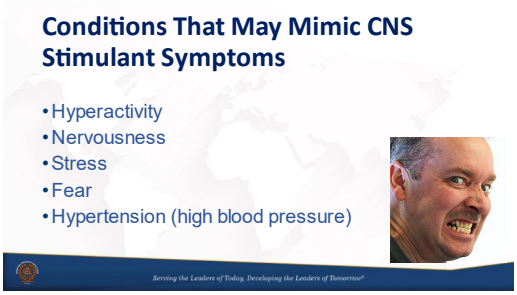


- Restlessness
- Anxiety
- Excited
- Exaggerated reflexes
- Bruxism (grinding of teeth)
- Runny nose
- Paranoia
- Euphoria
- Loss of appetite

- Loss of weight
- Dilated pupils

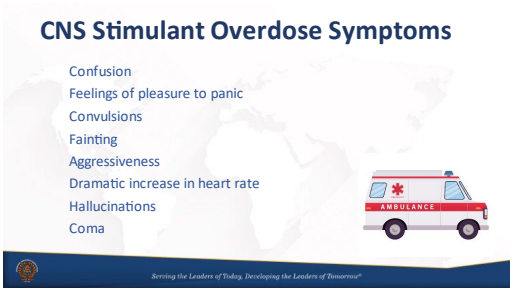
Other Conditions That May Mimic CNS Stimulants Indicators:

- Hyperactivity
- Nervousness
- Stress Fear
- Hypertension



Possible CNS Stimulant Overdose Symptoms:

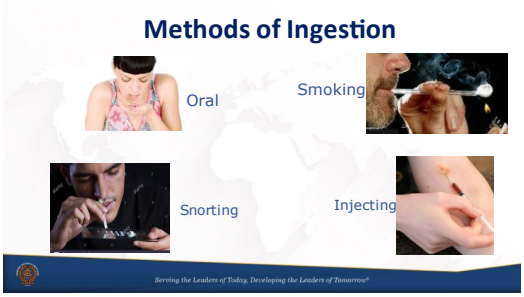
- Confusion
- Feelings of pleasure to panic
- Convulsions
- Fainting
- Aggressiveness
- Dramatic increase in heart rate
- Hallucinations
- Coma



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

Typical Methods of Ingestion:

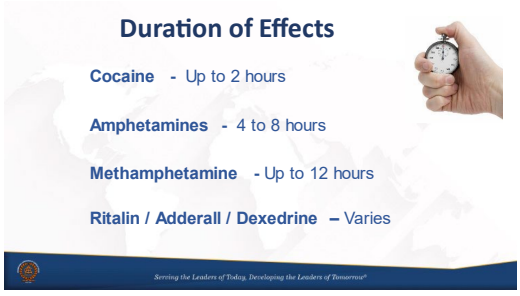
- Oral Smoking
- Snorting
- Injecting



Point Out: Smoking produces an instant high

Duration of Effects:

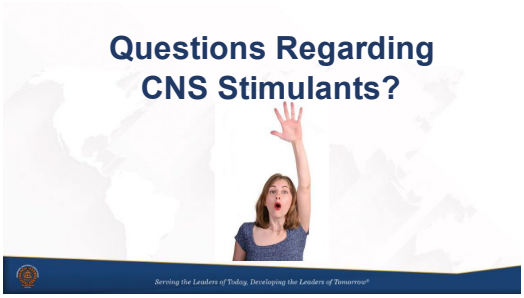
- Cocaine (Powder): ***Note: Snorted***
  - Onset/immediate
  - Duration – up to 2 hours



- Cocaine (Crack): ***Note: Smoked***
  - Onset/immediate
  - Duration – 5 to10 minutes
- Amphetamine: ***Note: Oral, pill form***
  - Onset – 30 to 40 seconds
  - Duration – 4 to 8 hours
- Methamphetamine (Crank or Speed):

  Note: Snorted, injected, smoked or taken orally

  - Onset – 30 to 40 seconds
  - Duration – Up to 12 hours



Solicit questions regarding CNS Stimulants

E. Hallucinogens

Hallucinogens are drugs that can cause hallucinations and typically cause the user to perceive things differently from what they 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 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 (Methylenedioxymethamphetamine). Street names include Ecstasy, Molly, X, XTC, and the love drug. A derivative of methamphetamine with both stimulant and psychedelic effects.
  - 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.

Point out: There are many designer psychedelics and new substances are being illegally marketed on a regular basis.

- Natural examples:
  - Salvia Divinorum – Has unique psychic effects likened to a combination of various hallucinogenic drugs. Often compared to the effects of LSD. Street names include Sage, Magic mint, and Sally D. (Legal in some states)
  - 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.
  - Morning Glory Seeds – LSD-like substances about one-tenth as potent as LSD. Street name include heavenly blue, flying saucers, and pearly gates.

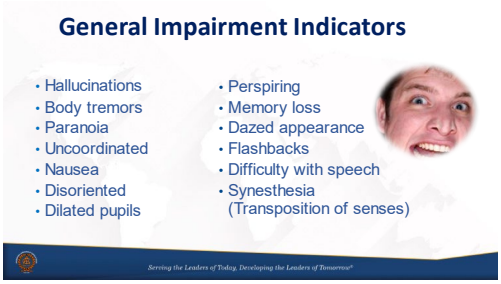
People under the influence of hallucinogens are usually extremely impaired and may exhibit bizarre behavior.

Some hallucinogen users experience mental flashbacks or sensations of a trip they had while under the influence of LSD or another hallucinogen months or years later. 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.

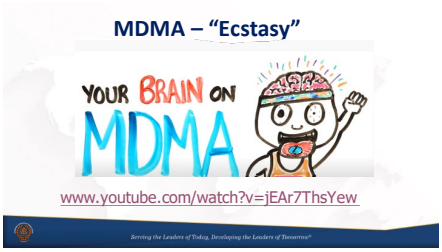
Point out: A flashback is a vivid memory. You will see physiological indicators (example: elevated pulse, blood pressure, etc.)

- General Indicators of Hallucinogen Impairment:

  - Dazed appearance
  - Body tremors
  - Perspiring
  - Paranoia
  - Disoriented
  - Nausea
  - Difficulty with speech
  - Piloerection (hair standing on end)
  - Statements suggesting hallucinations
  - Flashbacks
  - Uncoordinated
  - Memory loss
  - Synesthesia (Transposition of senses)
  - Dilated pupils



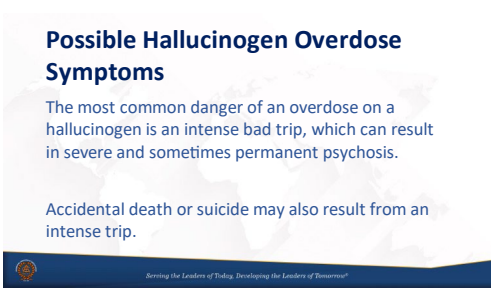
If internet is available, access the link provided in the slide to show video entitled, "Your Brain on MDMA." Use the video to generate interaction with the participants.



- 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.



Point out: Accidental death or suicide may also result from an intense bad trip.

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

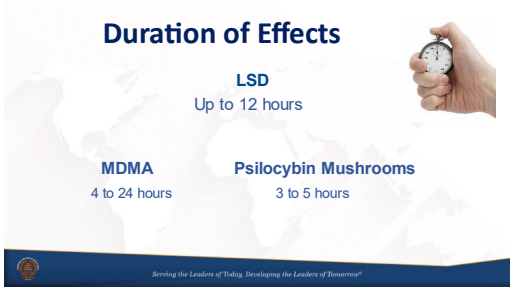
Point out: LSD can be absorbed through the skin. Extreme caution should be exercised when handling suspected materials containing LSD.

- Duration of Effects

  - LSD:
    - Onset – 30 to 60 minutes
    - Duration - up to 12 hours

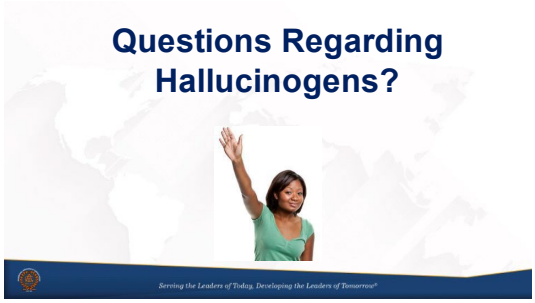
  - Psilocybin Mushrooms:
    - Onset - within 30 minutes
    - Duration – 3 to 5 hours

  - MDMA:
    - Onset - 30 minutes to 1 hour
    - Duration – 4 to 24 hours



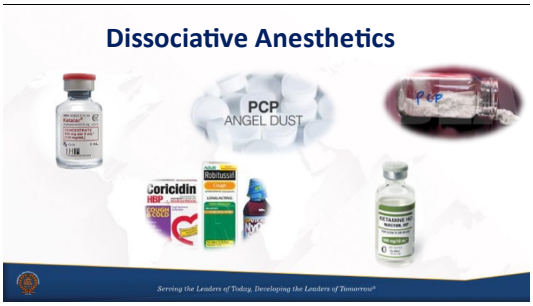
Source: Hallucinogen Duration of Effects - Drug Identification Bible, 2022 - 2023

Solicit questions regarding Hallucinogens.



F. 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:

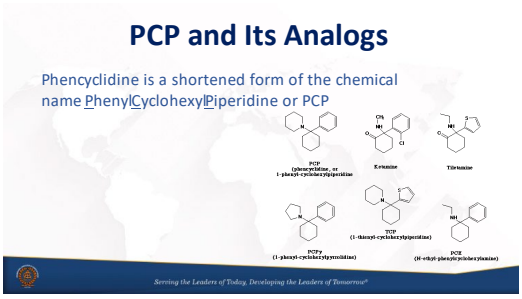


- Phencyclidine (PCP) – A illegal drug with a shortened title of the chemical name Phenylcyclohexylpiperidine. Originally developed for veterinary medicine use and never approved for human use due to its toxic and hallucinogenic effects. Has numerous street names including angel dust, peep, KJ, whack, and rocket fuel

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

- Dextromethorphan (DXM) – A legally produced synthetic analog of codeine with more specific activity at the cough receptors that the pain and euphoria sites. Found in many cough suppressants and is a popular over-the-counter substance abused by younger people. Often referred to as “purple drank”

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



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

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

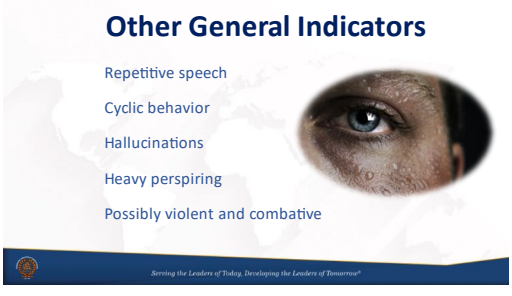
- Dissociative Anesthetics can cause hallucinations much like those induced by Hallucinogens

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

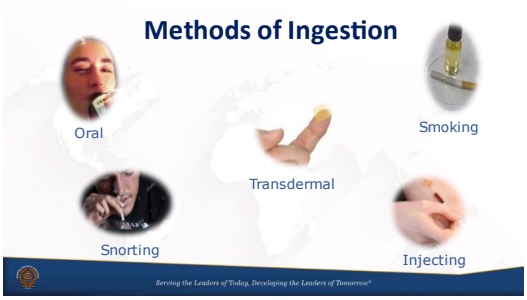
- General Indicators of Impairment:
    - Blank stare
    - Loss of memory
    - Perspiring heavily (may remove clothing)
    - Warm to touch
    - Incomplete, slurred verbal responses
    - Cyclic behavior
    - Agitation
    - Rigid muscle tone
    - Disoriented



- Non-responsive
- Chemical odor on breath or clothing

Sources: National Highway Traffic Safety Administration "Drugs and Human Performance Fact Sheets" April 2014; U.S. Dept. of Justice, Drug Enforcement Administration, Office of Diversion Control; National Institute on Drug Abuse (NIDA)

- Other Conditions That May Mimic Dissociative Anesthetic Impairment:
  - Mental disorders
  - Mental illness
- Possible Overdose Symptoms:
  - A deep coma, lasting for up to 12 hours
  - Seizures and convulsions
  - Respiratory depression
  - Possible cardiac problems
  - Bizarre, violent, and self-destructive behavior
- Typical Methods of Ingestion:
  - Smoked
  - Snorted
  - Oral
  - Injected
  - Transdermal absorption



Point out: Marijuana cigarettes laced with PCP are popular and is commonly abused in various parts of the country.

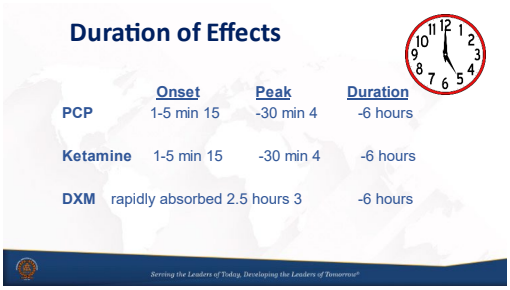
Point out: PCP and Ketamine can be absorbed through the skin. Extreme caution should be taken when handling materials suspected of containing these drugs.

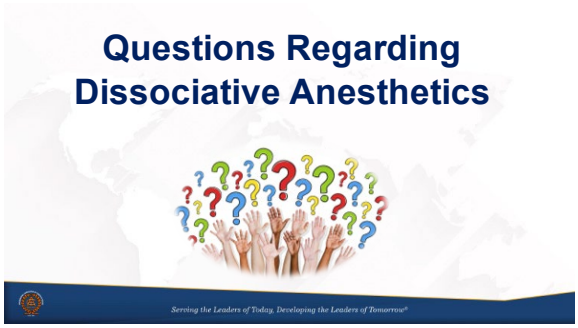
Duration of Effects:

- PCP
  - Onset – 1 to 5 minutes
  - Peak – 15 to 30 minutes
  - Duration – 4 to 6 hours

- Ketamine
  - Onset – 1 to 5 minutes
  - Peak – 15 to 30 minutes
  - Duration – 4 to 6 hours

- Dextromethorphan
  - Onset - rapidly absorbed
  - Peak – 2 to 5 hours
  - Duration – 3 to 6 hours





Solicit questions regarding Dissociative Anesthetics

G. Narcotic Analgesics

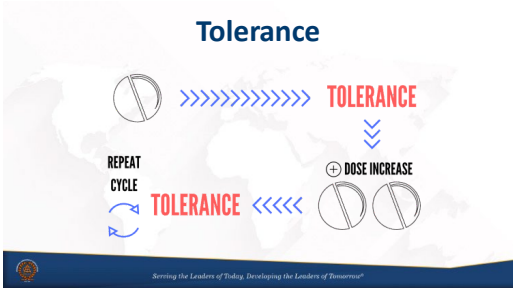
Narcotic Analgesics are a category of drugs refined from or are synthetic versions of the opium poppy's active ingredients. This category includes many drugs primarily developed for the treatment of moderate to acute pain, diarrhea, coughing, and other conditions.

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

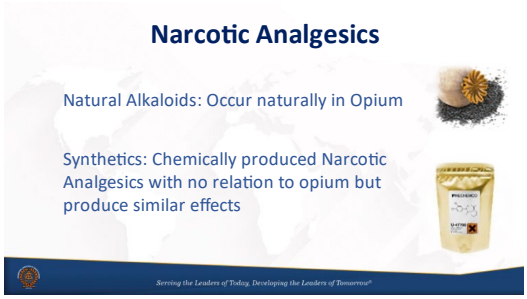
Most illicit users take opiate/opioid drugs to avoid emotional and physical pain, to experience euphoric effects, and to suppress withdrawal symptoms.

People 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 effect.

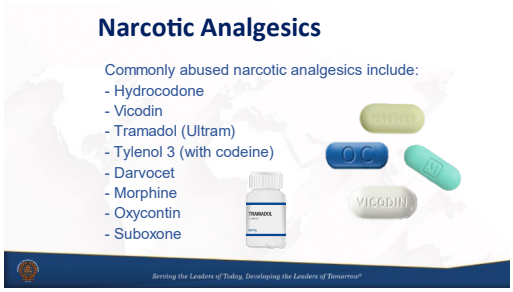


Point out: Habitual users of certain drugs may develop tolerance to the drug. Thus, they may exhibit relatively little evidence of impairment. However, when impaired, tolerant users may exhibit clinical evidence, i.e. constricted pupils.



Narcotic Analgesics include:

- Opium – Derived directly from the opium poppy plant.
- Natural Alkaloids of Opium:
  - Morphine (Infumorph®, Kadian®, Roxanol®, MS Contin®) – Used to treat moderate to severe pain that lasts for more than a few days. 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. Frequently combined with acetaminophen (Tylenol) or aspirin for more effective pain relief.



- Derivatives of Opium:
  - 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 United States). Typically injected into a vein, but can also be smoked, snorted or inhaled. Onset of effects is usually rapid and lasts for a few hours.

- Hydromorphone (Dilaudid®, Hydrostat®, Palladone®) - A short-acting (4 to 5 hours) semisynthetic opioid. 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 much attention for his high abuse. Street names include; “oxy,” “o’cotton,” and “hillbilly heroin.”

- Buprenorphine (Suboxone ®, Buprenex ®, Subutex ®, Butrans ®) – Semisynthetic powerful opioid agonist at low doses and an opioid antagonist at high does. 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.

- Synthetics: Chemically produced Narcotic Analgesics with no relation to opium but producing similar effects. They can include:

  - Hydrocodone (Vicodin ®, Hydodan ®, Tussend ®, Norco ®, Lorab ®) – Most widely prescribed opioid with many of the same actions as codeine, but produces less nausea. Used orally for relief of moderate to severe pain, but also commonly taken in liquid form as an antitussive/cough suppressant.

  - Meperidine (Demoral ®, Pethidine ®, Mepergan ®) – A short-acting opioid used to treat moderate-to-severe pain, help put people to sleep before surgery, and provide pain relief after childbirth.

  - Methadone (Dolophine ®) - An opioid used to treat pain and as maintenance therapy or to help with detoxification in people with opioid dependence.

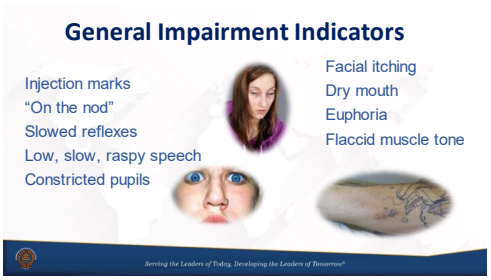
  - Oxymorphone (Numorphan ®) - Used to treat moderate to severe pain. Often used before surgery to cause sedation and to anxiety. As a narcotic pain reliever, it works by dulling the pain perception center in the brain.

- Fentanyl (Sublimaze ®, Actiq ®) - A highly potent, synthetic opioid pain medication with a rapid onset and short duration of action. It is 50 to 100 times more potent than morphine on a weight-for-weight basis. Involved in high amounts of drug overdoses.

If internet is available, access the link provided in the slide to show video entitled, "Your Brain on MDMA." Use the video to generate interaction with the participants.

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

- General Indicators:
  - "Track marks"
  - "On the nod"
  - Slowed reflexes
  - Low, slow, raspy speech
  - Facial itching
  - Dry mouth
  - Euphoria
  - Flaccid muscle tone
  -



Point out: "On-the-nod" is described as a semi-conscious state resembling sleep.

Point out: These are just general indicators and not found in everyone.

- Psychological effects:
  - Relief from the symptoms of withdrawal
  - Euphoria
  - Relief from pain

- Other Conditions That May Mimic Narcotic Analgesic Impairment Symptoms:

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

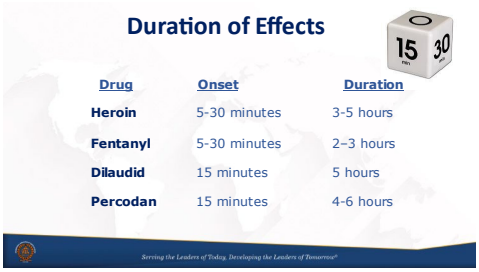
Possible Overdose Symptoms:

- 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

- Duration of Effects:



  - Heroin:
    - Onset – 5 to 30 minutes
    - Duration – 4 to 6 hours
  - Methadone:
    - Onset – 5 to 30 minutes
    - Duration - up to 24 hours
  - Dilaudid:
    - Onset - 15 minutes
    - Duration - 5 hours
  - Percodan:
    - Onset - 15 minutes
    - Duration – 4 to 6 hours
  - Fentanyl:
    - Onset - 15 minutes
    - Duration – 2 to 3 hours

With the emergence of Fentanyl abuse and other narcotic analgesic drugs, it has become necessary for many workplaces to have the availability of Narcan or Naloxone and train people in it's use.

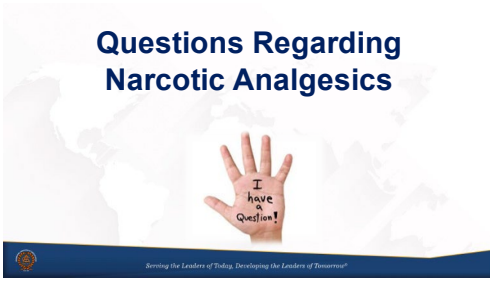
Narcan (Naxoxone) is a medicine that rapidly reverses an opioid overdose. It is an opioid antagonist. This means that it attaches to opioid receptors and reverses and blocks the effects of other opioids. Naloxone can quickly restore normal breathing to a person if their breathing has slowed or stopped because of an opioid overdose.

Narcan has no effect on someone who does not have opioids in their system, and it is not a treatment for opioid use disorder.

Naloxone should be given to any person who shows signs of an opioid overdose or when an overdose is suspected. Naloxone can be given as a nasal spray or it can be injected into the muscle, under the skin, or into the veins.

Naloxone works to reverse opioid overdose in the body for only 30 to 90 minutes. But many opioids remain in the body longer than that. Because of this, it is possible for a person to still experience the effects of an overdose after a dose of naloxone wears off. Also, some opioids are stronger and might require multiple doses of naloxone. Therefore, one of the most important steps to take is to call 911 so the individual can receive immediate medical attention.

People who are given naloxone should be observed constantly until emergency care arrives. They should be monitored for another 2 hours after the last dose of naloxone is given to make sure breathing does not slow or stop.



Solicit questions regarding Narcan use and Narcotic Analgesics

H. Inhalants

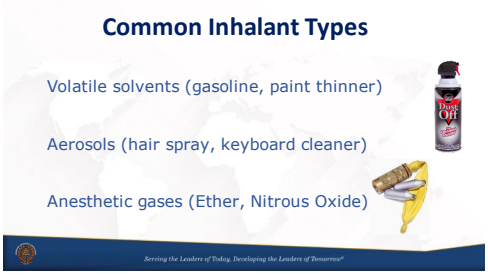
Inhalants are breathable chemicals that produce mind-altering results. They are also referred to as “deliriants” and comprise a wide variety of substances and delivery methods: volatile liquids that give off fumes, gases that come in pressurized tanks or bottles, and aerosol cans that are sprayed.

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 other substances.

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 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 so 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, amyl nitrite in particular, 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, and shoe cleaners. Nitrates are sometimes called "poppers" because amyl nitrates were formerly packaged in glass capsules wrapped in cotton, and they broke open with an auditable popping sound.

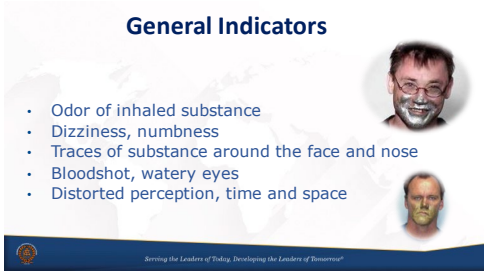
People under the influence of inhalants typically exhibit impairment similar to alcohol intoxication.

Subjects using inhalants are commonly referred to as "huffing."

Expected results of observation/indicators of Inhalant impairment include:

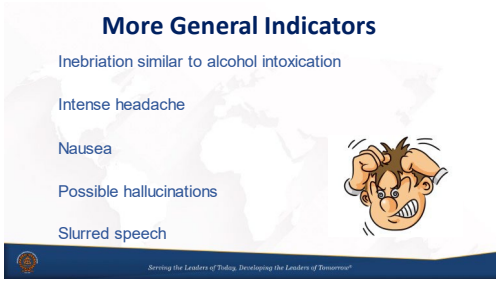
- General Indicators:

  - Odor of inhaled substance
  - Dizziness, numbness
  - Possible traces of substance (face, nose, hands)
  - Bloodshot, watery eyes
  - Distorted perception, time, and space
  - 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



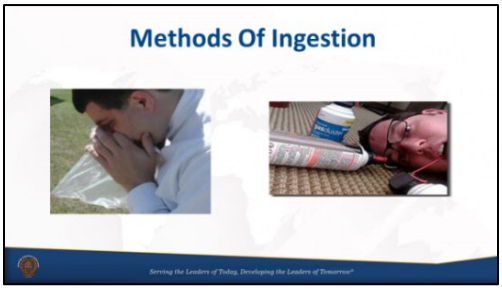
- Possible Overdose Symptoms:

  - Coma
  - Unconscious/Unresponsive

- 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



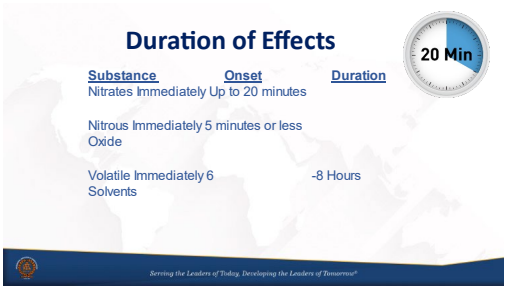
- Duration of Effects:

  - Onset is typically immediate
  - Duration:

    - Nitrates - up to 20 minutes (Amyl, Butyl, “Rush”)

    - Nitrous Oxide - 5 minutes or less

    - Volatile solvents – 6 to 8 hours (gasoline, paint)



Inhalants are easily accessible in the work environment. Most Inhalants are readily available in retail markets. Paints, cleaning solvents, etc., are easily accessible.

Solicit questions regarding Inhalants

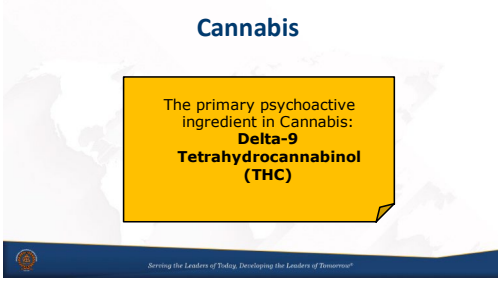
I. Cannabis

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 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. THC is the chemical in marijuana responsible for producing the euphoria or “the high.”



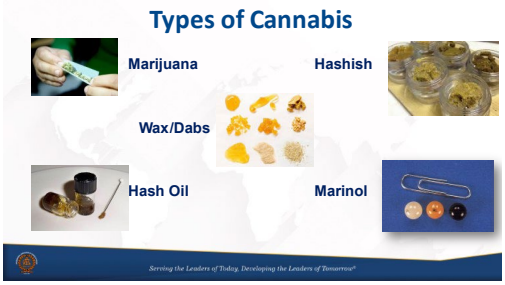
Cannabidiol (CBD) another chemical in marijuana and is considered non-psychoactive and lacks the intoxicating properties of THC. There is some evidence that CDB may hold medicinal value to treat several medical conditions such as neurological disorders (i.e. seizures and epilepsy), psychosis and anxiety.

Although the current national THC average level of marijuana is approximately 11%, any states report recreational marijuana is approximately 30% THC. This does not include high-potency extract concentrates, which can have 80 - 90% or more THC.

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.

If internet is available, access the link provided in the slide to show video entitled, "Your Brain on Marijuana." Use the video to generate interaction with the participants.

One use of THC is called "Dabbing" which is a concentrated, high potency form of THC. Dabbing is a way to get the quickest, long-lasting high with a single inhale. A single puff from a pipe or vaping pen can give the effect of smoking many joints. Unfortunately, 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.

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.

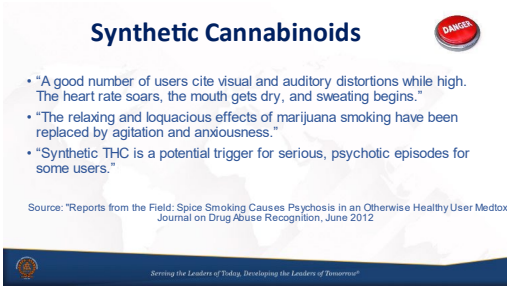
Edible cannabis or marijuana when consumed in foods can cause the effects to come on slower. However, because edibles containing marijuana are often unlabeled or poorly labeled, users can use too much waiting for the "high" and can end up in an emergency situation.

If internet is available, access the link provided in the slide to show video entitled, "Your Brain on Edibles." Use the video to generate interaction with the participants.

Synthetic Marijuana

Synthetic marijuana or synthetic cannabinoids have quickly become a worldwide concern. They quickly came on the market in the early 2000's and continue to evolve. These products go by many different names or identifiers. Spice, which is sometimes also called K2, herbal incense, or "fake weed," is one of the more popular or mor e familiar synthetic cannabinoids.

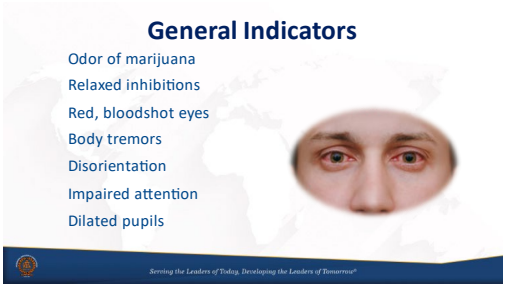
Spice and similar products consist of shredded dried plant material that has been sprayed with chemicals designed to act on the same brain cell receptors as THC but are often much more powerful and unpredictable. These products are typically labeled "not fit for human consumption," and most are illegal.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



People under the influence of Cannabis are typically relaxed, care-free acting.

- General Indicators:
  - Odor of marijuana
  - Relaxed inhibitions

- Marked reddening of the whites of the eyes
- Body tremors
- Disorientation
- Attention difficulties
- Impaired perception of time and distance
- Marijuana debris in the mouth
- Eyelid tremors
- Increased appetite



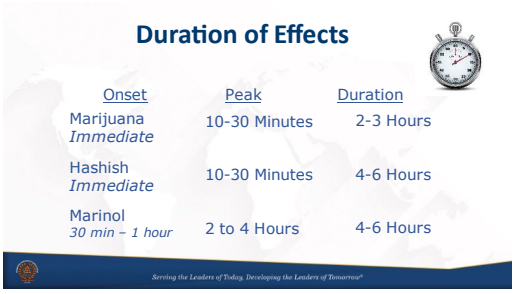
- Other Conditions That May Mimic Cannabis Impairment Symptoms:
  - Some medical conditions can be associated with a lack of attention. An example would be Attention Deficit Disorder (ADD)

Point out: This can make persons very unsafe when the ability to divide their attention or focus on specific tasks is impaired.

- Possible Overdose Symptoms:
  - Sharp personality changes (Paranoia)
  - Possible psychosis
  - Excessive vomiting (Hyperemesis Syndrome)

- Long-term Effects on Cannabis Use:
  - Lung damage
  - Chronic bronchitis
  - Lowering of testosterone
  - Possible birth defects
  - Chronic reduction in attention span
  - Withdrawal is similar to alcohol dependence withdrawal

- Methods of Ingestion:
  - Smoked
  - Oral
  - Transdermal (patches)



- Duration of Effects:
  - Smoked Cannabis
    - Onset – 8 to 9 seconds
    - Peak – 10 to 30 minutes
    - Duration – 3 to 4 hours

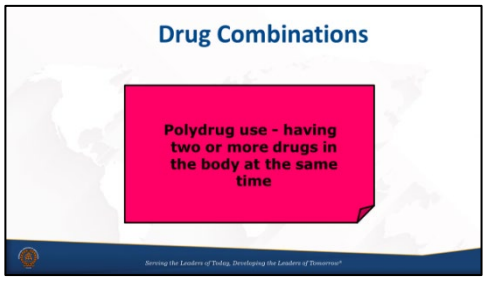
- Edibles
  - Up to 8 hours

Point out: Blood and urine tests can continue to disclose evidence of marijuana use days after its use. Positive drug tests in urine do not always equate to impairment.

Solicit questions regarding Cannabis

J. Drug Combinations

Poly-drug use refers to the use of two or more psychoactive drugs in combination to achieve a particular effect. In many cases one drug is used as a base or primary drug, with additional drugs to leaven or compensate for the side effects of the primary drug and make the experience more enjoyable with drug synergy effects, or to supplement for primary drug when supply is low.

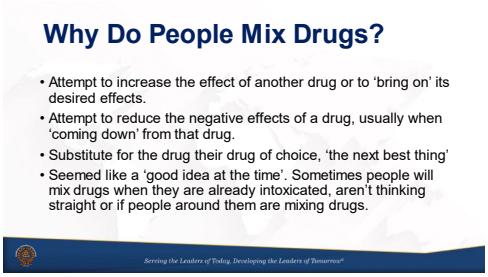


For our purposes, poly-drug use is defined as: *having two or more drug categories in the body at the same time.*

It is very common to encounter poly-drug users more than single drug users.

Per the National Cannabis Prevention and Information Center (NCPIC), the most common type of poly-drug mix is marijuana and alcohol.

A person addicted to both can experience the same symptoms but to a wholly unpredicted level. This may be due to the psychedelic properties of marijuana, which can affect the mind in different ways. These psychedelic effects may be heightened with the sedative effect of alcohol. This, in turn, can increase the risk for psychological problems and psychotic symptoms.



NCPIC also reported that alcohol can increase the rate of absorption of THC, the primary active component of cannabis, or marijuana. Taking alcohol with marijuana can strengthen the effect of the latter and cause a condition referred to as "greening out." This is a term used to describe when marijuana users experience nausea or sickness after smoking marijuana. Alcohol was often found in combination with one or more drugs.

If internet is available, access the link provided in the slide to show video entitled, "Drunk and High." Use the video to generate interaction with the participants.

If available, present local data to demonstrate the poly-drug use in your area/state.

Drug combinations often produce conflicting signs and symptoms.

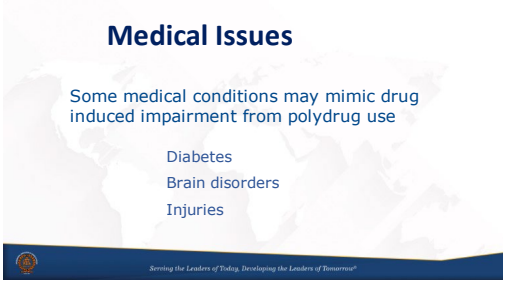
An example would pupil size. A person under the influence of Cocaine and Heroin could have pupils that are small (constricted), large (dilated) or normal in appearance.

Point out: Don't discount something because the signs and symptoms you see do not fit into any specific category.

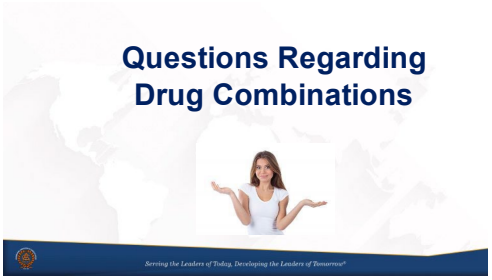
- Medically Impaired Individuals:

  Some medical conditions may mimic drug induced impairment:

  - Diabetes
  - Brain disorders
  - Injuries



Solicit questions regarding poly-drug use and poly-drug examples



Solicit questions regarding the drug categories and their effects.

30 Minutes

Session V POLICY & PROCEDURES

Overview

Objectives

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

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

B. Discuss local issues regarding possession and use of drugs in the workplace.

CONTENT SEGMENTS

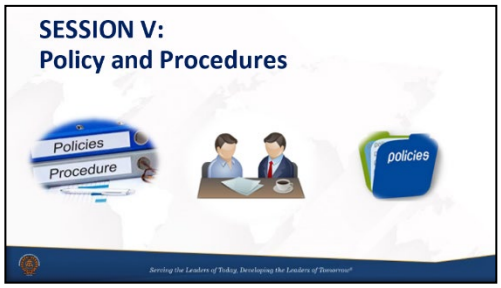
A. Review of Company Policy

B. Words to Use When Talking with Employees

C. Words That May Cause a Negative Reaction

LEARNING ACTIVITIES

Instructor Led Presentations



Note: Prior to class, ask the employer for a copy of their policy on possession of drugs and employees under the influence of drugs.

A. Review of Policy

Remember: Always follow your company policy when dealing with drug-impaired individuals.

Ask: Does your company have a policy on possession of drugs? If so, does it address employees under the influence of drugs?

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

- Prohibiting the unlawful manufacture, distribution, dispensing, possession, use, sale, purchase, consumption, or being under the influence of a controlled substance on company property or as part of any company 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 company premises, including meal periods and breaks.
- Prohibiting being under the influence of alcohol at any company function.
- Prohibiting the use or being under the influence of unauthorized drugs while attending company approved functions and that a violation of this policy will constitute grounds for disciplinary action and/or referral to law enforcement and prosecution.

Instructors: Bring copies of laws and local ordinances. Provide an overview of the laws, but don't just read the statutes to the class. Some may have problems understanding the legal jargon. A concise explanation is more valuable.

Address any differences between company policy and state criminal laws. Be able to address these kinds of questions.

Stress the importance of participants knowing and understanding their company's policies. Inform the participants that they should review the policies after this training to ensure they are consistent with what they can do after the training.

If available, have the company administrator or supervisor talk about their policy and procedure involving drug possession and impairment.

What to Do When You Suspect an Employee Is Using Drugs

Stress the importance of doing something!

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

Participants should gather as much information as possible to substantiate any suspicions.

Observations and changes that ***may*** indicate drug abuse:

- Social/Behavioral symptoms: may include changes in emotional functioning such as depression, irritable mood, nervousness, euphoria, and apathy
- Cognitive functioning: may include poor concentration, sensation of slowed time, confusion, rambling flow of thoughts and speech, poor memory and attention
- Biological/Physical symptoms: may include changes in the employee'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, chills
- Psychomotor agitation: may include pacing, hand wringing, picking at skin, fidgeting, and restlessness
- Psychomotor retardation: 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

There may be other reasons in the employee's life that would account for changes you observe (death in the family, domestic violence, divorce, etc.).

If possible, discuss your observations with a supervisor having contact with the employee.

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 to not place additional stress on the individual

Point out to avoid public conversations where you would or could be overheard discussing this issue.

- Do not accuse the employee.
- Make your observations and get the facts using all your senses. **Just the facts.**

Team Effort

- Supervisors
  - First line of defense
  - Encounter the employee daily
  - Observe physical and behavioral changes
  - Document your observations
- Employer, Administrators
  - Take appropriate action consistent with policies
  - Include all applicable team members
  - Consider the observations of employees and supervisors
  - Consider the welfare and safety of the entire staff
  - Ensure the employee has access to an Employee Assistance Program (EAP)

Stress the importance of reviewing and following the current policy(s) of the employer and company.

- Others
  - Emergency medical personnel
  - Security
  - On-Duty law enforcement personnel

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

Remind participants they need to be better observers by utilizing all of their senses. Their input will be included in the overall assessment of the employee. Follow company policy.

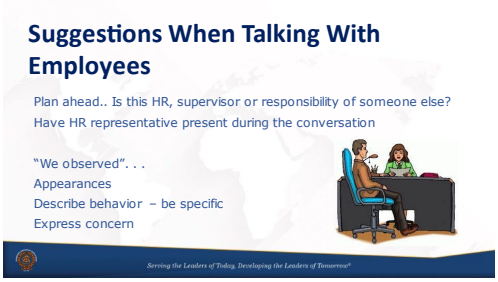
First Contact (Supervisors/HR)

In order to take appropriate action and assist an employee suspected of drug impairment, it is necessary to be familiar with the signs and symptoms of an alcohol or other drug problem. 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 an employee's problem.

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 an employee and discussing your concern. The following are some tips for conducting an informal intervention:

- Select a private location
- Let the employee know that you are genuinely concerned
- Describe to the employee the specific behaviors that have caused the concern
- Speak to the employee in an objective, nonjudgmental manner
- Be prepared for the employee 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 employee

Interventions tips*:*



- Avoiding lecturing and admonishing
- Have a positive attitude towards the employee
- Avoiding judgmental responses
- Avoiding medical jargon
- Being attentive, genuine, and empathic
- Identifying the problem
- Avoid writing during the interview, especially during sensitive questions
- Criticizing the activity, not the employee and highlighting the positive.

Remember that even if the employee 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 employee yourself but would still like to help, involve another member of the team.

C. Words That May Cause a Negative Reaction

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

Solicit questions regarding company policies, intervention procedures and contact with employees.

30 Minutes

Session VI REFERENCES

Overview

Objective

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

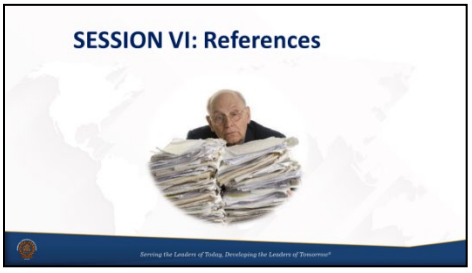
1. Access additional references and resources provided.

Content Segments	Learning Activities
A. Internet Resources	Instructor-led Presentations
B. Printed Resources/References	
C. Review of References, Resources and Impairment Chart	
D. Course Conclusion, Post-Test and Critique	

Appendix 6A: Suggested Additional References and Resources

Appendix 6B: General Indicators Chart

Appendix 6C: Duration and Detectability of Drugs in Urine



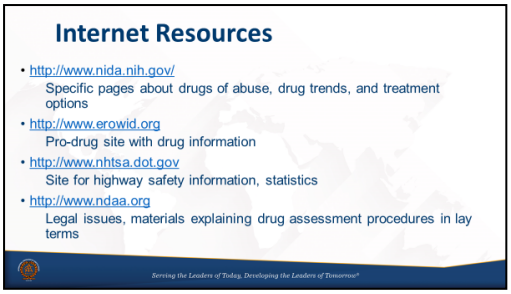
SESSION SIX: REFERENCES

There are numerous references available to administrators, supervisors and others regarding drugs and their various impairing effects. Some of those resources are covered in this session.

A. Internet Resources:

National Institute of Drug Abuse - http://www.nida.nih.gov

- Contains specific pages about drugs of abuse, drug trends, and treatment options



Erowid - https://www.erowid.org

- A pro-drug non-profit educational and harm-reduction resource with online information about psychoactive drugs, plants, chemicals, and drug effects

National Traffic Safety Administration - http://www.nhtsa.dot.gov

- Government site for highway safety information and statistics

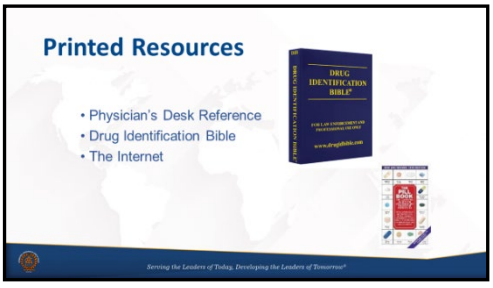
National District Attorneys Association - http://www.ndaa.org

- Site for legal issues and materials explaining drug assessment procedures in lay terms

Drugs.Com Pill Identifier - http://www.drugs.com/pill_identification.html

- A pill identification resource site

B. Printed Resources/References



1. Physician's Desk Reference
   Available at:
   www.pdr.net/resources/pdr-books

2. Drug Identification Bible
   Amera-Chem, Inc.
   Available at: www.drugidbible.com

3. Drugs and Human Performance Fact Sheets National Highway Traffic Safety Administration
Available at:
https://one.nhtsa.gov/people/injury/research/job185drugs/technical-page.htm

4. Street Drugs, 2022
Publishers Group West, LLC
Available at: www.streetdrugs.org

5. Uppers, Downers, All Arounders, 8th Edition
CNS Productions, Inc., Medford, Oregon
Available at: www.cnsproductions.com

C. Review of References, Resources, and Indicators Chart

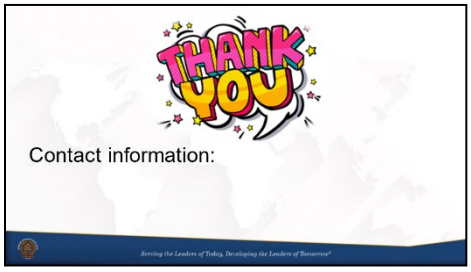
Review the References, Resources and Impairment Indicators Chart located at end of the Participant Manual.

D. Course Conclusion and Wrap-Up

- Post-Test
- Critique

If applicable, give the 10 question Post-Test located in the Administrator Guide of the Instructor Guide. Go through each of the questions and answers with the participants. Have participants complete the course critique located in the Administrator Guide.

Thank the participants and close the training.
Provide contact information.



Appendix 6A

SUGGESTED ADDITIONAL REFERENCES AND RESOURCES

ABCs of the Human Body. The Reader's Digest Association, Inc., Pleasantville, New York, 1990.

The Brain. Richard Restak, M.D., Bantam Books, Toronto, 1984.

Chocolate to Morphine: Understanding Mind-active Drugs. Andrew Weil, M.D. and Winifred Rosen, Houghton Mifflin Company, Boston, 2004.

Cocaine: The Mystique and the Reality. Joel L. Phillips and Ronald D. Wynne, Ph.D., Avon Books, New York, 1980.

Complete Guide to Prescription & Non-prescription Drugs. H. Winter Griffith, M.D. HP Books, Inc., Tucson, AZ, 2019.

Complete Guide to Symptoms, Illness & Surgery, 6th Edition. H. Winter Griffith, M.D. HP Books, Los Angeles, 2012.

Designer Drugs. M.M. Kirsch. CompCare Publications, Minneapolis, 1986.

Drugs and Society, 14th Edition. Weldon L. Witters Ph.D. & Peter J. Ventucelli, Ph.D. Jones & Bartlett Publishers, Boston, 2020.

Heroin Use: Legal and Medical Aspects. Paul R. Edholm, Jr., Richard P. Neidorf. Heroin Information Publications, Beverly Hills, CA, 2022.

The Little Black Pill Book. Bantam Books, Toronto, 1993.

Marijuana Alert. Peggy Mann. McGraw-Hill Paperbacks, 1985.

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The Physician's Guide to Psychoactive Drugs, 4th Edition. Richard Seymour, M.A. and David Smith, M.D. The Haworth Press, New York, 1997.

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DRUG INFORMATION SOURCES

National Institute of Drug Abuse
5600 Fishers Lane
Rockville, Maryland 20857
Website - http://www.nida.nih.gov

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 6B (Next page)

Impairment Indicators	CNS Depressants	CNS Stimulants	Hallucinogens	Dissociative Anesthetics	Narcotic Analgesics	Inhalants	Cannabis
GENERAL INDICATORS	Uncoordinated Disoriented Sluggish Thick, slurred speech Drunk-like behavior Drowsiness Droopy eyes Fumbling	Restlessness Body tremors Excited Euphoric Talkative Exaggerated reflexes Anxiety Grinding teeth (bruxism) Redness to nasal area Runny nose Loss of appetite Insomnia Increased alertness Dry mouth Irritability	Dazed appearance Body tremors Synesthesia Hallucinations Paranoia Uncoordinated Nausea Disoriented Difficulty in speech Perspiring Poor perception of time & distance Memory loss Disorientation Flashbacks NOTE: With LSD, piloerection may be observed (goose bumps, hair standing on end)	Perspiring Warm to the touch Blank stare Very early angle of HGN onset Difficulty in speech Incomplete verbal Responses Repetitive speech Increased pain threshold Cyclic behavior Hallucinations Possibly violent & Combative Chemical odor	Droopy eyelids "On the nod" Drowsiness Depressed reflexes Low, raspy, slow speech Dry mouth Facial itching Euphoria Fresh puncture marks Nausea Track marks	Residue of substance around nose & mouth Odor of substance Possible nausea Slurred speech Disorientation Confusion Bloodshot, watery eyes Lack of muscle control Flushed face Non-communicative Intense headaches **NOTE: Anesthetic gases cause below normal blood pressure; volatile solvents and aerosols cause above normal blood pressure.	Red, bloodshot eyes Odor of marijuana Lack of concentration Marijuana debris in mouth Body tremors Eyelid tremors Relaxed inhibitions Increased appetite Altered perception of time & distance Disorientation Possible paranoia
DURATION OF EFFECTS	Barbiturates 1-16 hours Tranquilizers 4-8 hours	Cocaine Up to 2 hours Meth Up to 12 hours	Duration varies widely from one hallucinogen to another. LSD 10 – 12 hours	PCP Onset: 1-5 minutes Exhibits effects up to 4-6 hours DXM Onset: 15-30 minutes	Heroin: 3-5 hours Fentanyl: 2-3 hours Others: Vary	6-8 hours for most volatile solvents Anesthetic gases and aerosols - very short duration.	3 to 4 hours (Smoked) Edibles: Up to 8 hours
USUAL METHODS OF ADMINISTRA-TION	Oral Injected Insufflation	Insufflation (snorting) Smoked Injected Oral	Oral Insufflation Smoked Injected Transdermal	Smoked Oral Insufflation Injected Eye drops	Injected Oral Smoked Insufflation	Inhalation (Historically, have been taken orally)	Smoked Oral Transdermal
OVERDOSE SIGNS	Shallow breathing Clammy skin Pupils dilated Rapid, weak pulse, coma	Agitation Increased body temperature Hallucinations	Long intense "trip"	Long intense "trip"	Slow, shallow breathing Clammy skin Coma Convulsions	Possible psychosis Respiration ceases Severe nausea or vomiting Risk of death	Fatigue Paranoia Possible psychosis

Appendix 6C

DURATION OF DETECTABILITY OF DRUGS IN URINE

DRUG	DETECTABLE TIME
Amphetamine/methamphetamine	**12-72 hours**
Barbiturates	
Amobarbital (Tuinal)	2-4 days
Pentobarbital (Fiornal)	2-4 days
Phenobarbital (Nembutal)	Up to 30 days
Secobarbital (Seconal)	2-4 days
Benzodiazepines	
Alprazolam (Xanax)	Up to 30 days
Diazepam (Valium)	Up to 30 days
Chlordiazepoxide (Librium)	Up to 30 days
Cocaine Metabolites	12-72 hours
Cannabis (Marijuana)	
Single use	3 days
Moderate smoker (4 times/week)	5 days
Heavy smoker (daily)	10 days
Chronic smoker (daily)	21-27 days
Methadone	1-4 days
Opiates (Narcotic Analgesics)	

Codeine	2-4 days
Hydromorphone (Dilaudid)	2-4 days
Morphine/Heroin	2-4 days

PCP

Casual Use	Up to 5 days
Chronic use	Up to 14 days

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: National Institute on Drug Abuse; PharmChem Laboratories. Reprinted from *The Drug Identification Bible 2022*