

# Decoding the DRE Program: A Judge's Primer

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American Bar Association National Judicial Fellow

August 1, 2024



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## Learning Objectives

- Demonstrate an understanding of the impact of drug use on the tasks critical to driving
- Outline the key components of the twelve-step DRE protocol
- Evaluate the admissibility of DRE testimony in impaired driving cases

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**CAUTION  
NEW DRIVER**



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Why is it  
important?

Driving is “a complex activity requiring alertness, divided yet wide-ranging attention, concentration, eye-hand-foot coordination, and the ability to process visual, auditory, and kinesthetic information quickly.”

P. Larkin, *Medical or Recreational Marijuana and Drugged Driving*, 52 Am. Cr. L. Rev. 454 (2015)

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## The Big Four:

1. Judgment
2. Vision and visual perception
3. Muscular coordination
4. Reaction time

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## Impaired Driving By the Numbers

- In 2022, there were 13,524 alcohol-related traffic fatalities in the U.S, representing 32% of all traffic deaths
- 32 people in the U.S. die every day in impaired-driving crashes – one person every 45 minutes
- In 2019, 1,024,508 drivers arrested for DUI, with 121m impaired driving episodes
- An impaired driver gets behind the wheel and drives between 300 and 1,200 times before first arrest

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## The good news and the bad news

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2/3 of first-time impaired drivers self-correct and do not recidivate

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40% of fatally injured impaired drivers have a history of repeat DUI offenses

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Less than 5% of drivers account for about 80% of the impaired driving episodes

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## Views on Substance Use and Driving

- Drivers perceive the use of marijuana and alcohol differently
- 95% of survey respondents believe it is dangerous to drink and drive
- 69% of the same respondents believe it is dangerous to use marijuana and drive

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## Risk of Motor Vehicle Collisions

- Alcohol use alone consistently associated with elevated motor vehicle collision risk
- Cannabis use alone (at all levels) not consistently associated with elevated motor vehicle collision risk
- Alcohol and cannabis in combination consistently associated with elevated motor vehicle collision risk

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## Drugged Driving Defined

Driving after the use of impairing substances other than alcohol or combined with alcohol

- Illegal drugs
- Prescription drugs
- Over-the-counter medications
- Chemical consumption
- Combination of any of the above and/or with alcohol

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## Question

How many people in the U.S. drive under the influence of drugs annually?

1. 10 million
2. 25 million
3. 62 million
4. 100 million

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## Struggling with Drug Data

- Labs may not test for drugs if driver has reached an illegal/per se blood alcohol level because there is already enough evidence to support an impaired driving charge – stop limit testing
- Many drivers who cause crashes have both drugs and alcohol/more than one drug in their system, making it difficult to know which substance had the greater effect
- Data is reported inconsistently and difficult to correlate
- Some drugs stay in the system for days or weeks after use, making it difficult to determine when the drug was used, and how and if it impaired driving

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## Why is this difficult?

- Varied substances with different means of impairing the driver
- The lack of information about many potentially impairing drugs
- Individual differences, sensitivity and tolerance
- Myriad of ways various substances interact
- Study limitations/data incomplete
- Testing inadequacies/failure to test for all drugs

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## Driving Under the Influence of Drugs (DUID)

- DUID offenders 5x more likely to reoffend as compared to DUI offenders
- DUID where a scheduled prescription was the impairing drug reoffend much less frequently (about 17%) compared to those consuming illicit drugs (68%)

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# Drug Impaired Driving

- Recreational cannabis use associated with increased motor vehicle crashes
- Chronic, heavy recreational cannabis use associated with worse driving performance
- In 2022, daily or near daily marijuana use exceeded daily alcohol use

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- 137.4m current alcohol users
- 61m past month binge drinkers (44.5%)
- 61.9m past month marijuana users (22%)
- 8.9m opioid misusers in the past year
- 48.7m SUD in the past year
  - 29.5m AUD
  - 27.2m DUD
  - 8.0m both

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## What we know



### 2022 NTSB Report

Analyzed toxicology data from four labs including drivers arrested for DUID and fatally injured drivers:

Between 71% and 99% of drivers tested positive for one or more potentially impairing drugs

Approximately 50% of the drivers had more than one drug category present on toxicology screen

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that it's just alcohol

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**Table 3. Percentage of drivers who reported driving within 2 hours of using various potentially driver impairing medications within the past 30 days, United States, July–August 2021.**

Age Group	Antihistamines and/or cough medicines (%)	Antidepressants (%)	Rx pain medications (%)	Muscle relaxants (%)	Sleep aids, barbiturates, or benzodiazepines (%)	Amphetamines (%)	≥1 of these medications (%)	≥2 of these medications* (%)	≥3 of these medications* (%)
All drivers	38.9	60.8	32.6	21.6	9.2	73.1	45.0	63.3	70.8
16–18	32.8	55.7	29.3	27.6	4.7	56.4	40.9	56.6	46.1
19–24	31.8	52.8	20.1	0.0	0.0	1.0	39.3	54.1	83.6
25–39	36.5	74.7	28.4	20.3	13.8	80.7	44.8	69.6	70.0
40–64	43.1	60.9	40.5	22.7	8.4	61.9	48.6	64.2	72.7
≥65	34.4	49.3	26.6	22.8	10.9	74.3	38.9	58.2	64.6

Base: U.S. residents ages 16+ with a driver's license who reported driving and taking the corresponding medicine (or number of medicines) in past 30 days, weighted to reflect U.S. population. Red numbers indicate significantly different across age groups based on unadjusted statistical analysis (corrected Pearson F test). Blue shading indicates small sample size (<100). \*Not necessarily at the same time.

## Impaired Drivers: Not the Usual Suspects

## Impaired Drivers are Different

- Tend to score lower on traditional risk assessments
- Often lack an extensive criminal history
- High degree of denial – alcohol consumption is legal, highly prevalent and socially encouraged
- Tend to be employed and may have a stable social network
- Do not view themselves as criminals
- But, repeatedly engage in behavior that is dangerous

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## Co-Occurring Disorders

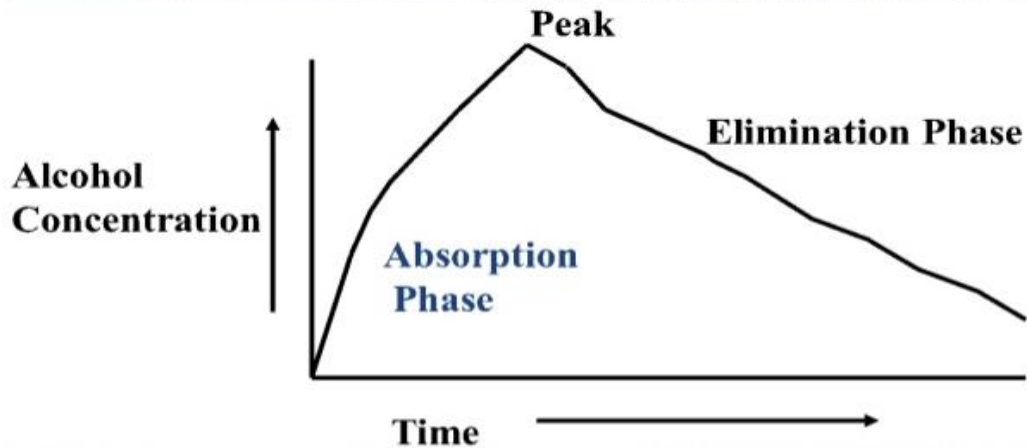
Study of repeat impaired drivers found 45% have a lifetime major mental health disorder

Mental health issues linked to impaired driving include:

Depression, bipolar disorder, conduct disorder, anxiety, anti-social personality, PTSD

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# Alcohol – A Simple Drug



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BLOOD ALCOHOL CONCENTRATION	NUMBER OF DRINKS	EFFECTS ON DRIVING
<b>0.02% BAC</b>		<ul style="list-style-type: none"> <li>• Decline in visual functions</li> <li>• Inability to perform two tasks at the same time</li> <li>• Loss of judgment</li> <li>• Altered mood</li> </ul>
<b>0.05% BAC</b>		<ul style="list-style-type: none"> <li>• Reduced coordination</li> <li>• Reduced ability to track moving objects</li> <li>• Difficulty steering</li> <li>• Slower response to emergency driving situations</li> </ul>
<b>0.08% BAC</b>		<ul style="list-style-type: none"> <li>• Reduced ability to concentrate</li> <li>• Short-term memory loss</li> <li>• Lack of speed control</li> <li>• Impaired perception and self-control</li> </ul>
<b>0.10% BAC</b>		<ul style="list-style-type: none"> <li>• Clear deterioration of reaction time</li> <li>• Reduced ability to maintain lane position</li> <li>• Reduced ability to brake appropriately</li> <li>• Slurred speech</li> </ul>
<b>0.15% BAC</b>		<ul style="list-style-type: none"> <li>• Substantial impairment in vehicle control</li> <li>• Loss of auditory information processing</li> <li>• Major loss of balance</li> <li>• Vomiting may occur</li> </ul>

Source: Centers for Disease Control and Prevention

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# THC and the Brain

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THC structure similar to the brain chemical anadamide

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The similar structure allows the drug to be recognized by and activate cannabinoid receptors and to alter normal brain communication

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Cannabinoid receptors abundant in the parts of the brain that regulate movement, coordination, learning and memory, higher cognitive functions such as judgment, and pleasure regions

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Activates the brain's reward system – which releases dopamine at levels higher than typically found, prompting a repetition of the behavior

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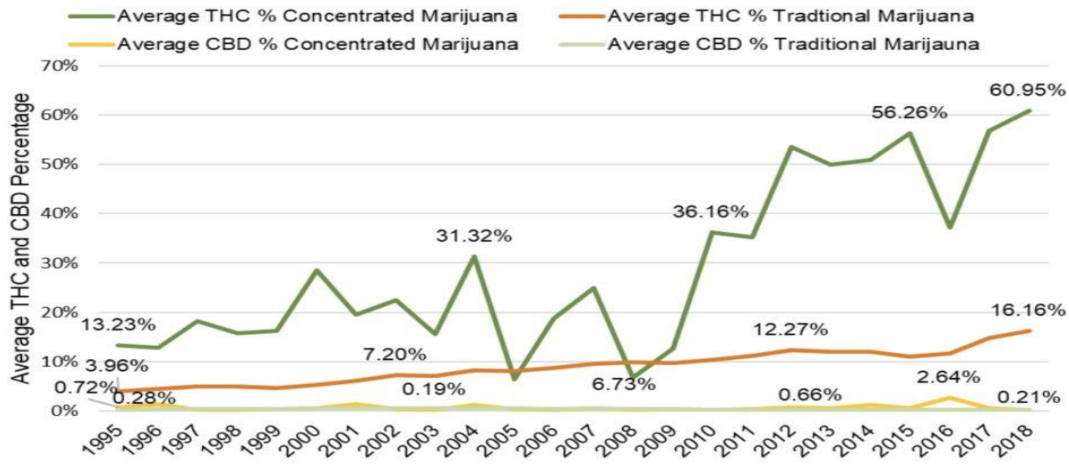
# Cannabis

- Affect varies by product, dose, route of administration, experience of user
- Short term effects – problems with memory and learning, distorted perception, difficulty in thinking and problem-solving and loss of coordination, difficulty sustaining and shifting attention and in registering, processing and using information
- Driving concerns – distortion of distance, and vigilance, loss of coordination in divided attention tasks

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# It's Not Your Grandpa's Weed

**Figure 71. Average THC and Cannabidiol Potency of Traditional and Concentrated Marijuana, 1995 – 2018**



Source: University of Mississippi

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## Marijuana's Effects on the Brain

**HYPOTHALAMUS**  
Controls appetite, hormonal levels and sexual behavior

**BASAL GANGLIA**  
Involved in motor control and planning, as well as the initiation and termination of action

**VENTRAL STRIATUM**  
Involved in the prediction and feeling of reward

**AMYGDALA**  
Responsible for anxiety, emotion and fear

**BRAIN STEM AND SPINAL CORD**  
Important in the vomiting reflex and the sensation of pain

**NEOCORTEX**  
Responsible for higher cognitive functions and the integration of sensory information

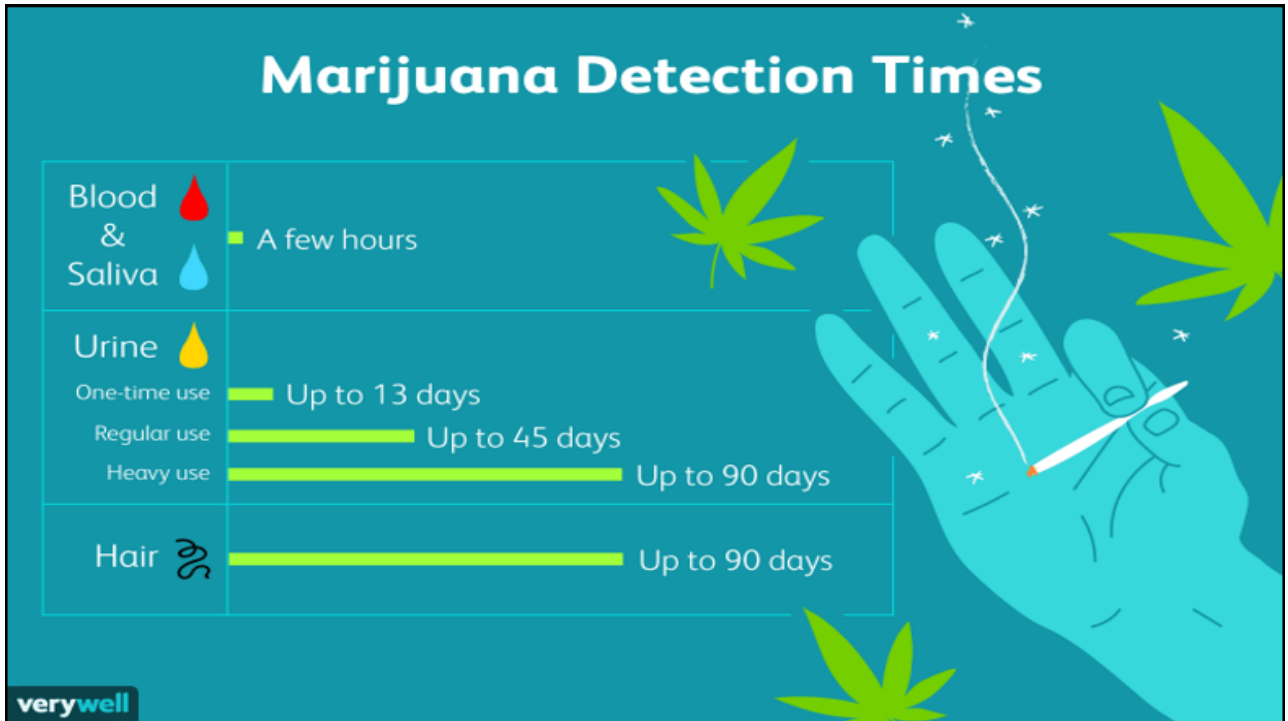
**HIPPOCAMPUS**  
Important for memory and the learning of facts, sequences and places

**CEREBELLUM**  
Center for motor control and coordination

© Alice Y. Chen, 2004. Adapted from *Scientific American*.

When marijuana is smoked, its active ingredient, THC, travels throughout the body, including the brain, to produce its many effects. THC attaches to sites called cannabinoid receptors on nerve cells in the brain, affecting the way those cells work. Cannabinoid receptors are abundant in parts of the brain that regulate movement, coordination, learning and memory, higher cognitive functions such as judgment, and pleasure.

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## What makes cannabis and alcohol use different?

- Alcohol eliminated at a fairly constant rate of 0.01%-0.03% per hour
- Peak effects of alcohol use occur at peak blood concentration
- THC concentration cannot be correlated to specific impairment
- THC dissolves in fatty tissue, which acts like a sponge to reduce measurable amounts in blood, saliva or breath
- THC rapidly moves from the blood stream to the brain, yet has a long half-life to metabolize
- As a result, impairment does not uniformly rise and fall based upon how much THC is present in bodily fluids
- Peak effects of cannabis occur after peak blood concentration

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No BAC for THC

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## WHAT ARE EFFECTS OF DRUGS ON DRIVING?

Driving under the influence of drugs affects you and everyone around you.



### MARIJUANA

Slows reaction time and impairs judgment of time and distance



### METHAMPHETAMINE OR COCAINE

Aggressive and reckless behaviors



### OPIOIDS

Drowsiness and impaired memory and thinking skills



### SEDATIVES

(benzodiazepines, barbiturates, etc.)  
Dizziness and drowsiness

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## Diphenhydramine (Benadryl, Unisom, Dramamine)

- Can act as both a stimulant and a depressant
- Diminishes cognitive and psychomotor performance, decreased alertness, decreased reaction time, impaired concentration, time estimation, tracking and attention, ability to maintain a constant distance and lane keeping
- A single 50 mg dose has been shown to cause significant impairment in measuring vehicle following, constant speed and lateral position – effects correspond to a BAC of 0.1



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## Dextromethorphan

- Synthetic analog of codeine
- Effects of recreational doses include dissociation of mind from body, creating a dream-like experience, disorientation, confusion, altered time perception, visual and auditory hallucinations
- Little to no effect on driving at therapeutic levels, but high doses result in significant impairment – marked drowsiness, impairment of mental and/or physical abilities required to perform driving tasks

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## Ketamine

- Decreased awareness of general environment, dream-like state, feelings of invulnerability, increased distractability, disorientation, intense hallucinations, impaired thought processes, out-of-body experiences, changes in perception about body, surroundings, time and sounds
- Increased reaction time, distorted perception of space, blurred vision
- Manufacturer suggests no driving within 24 hours of ingestion

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## Diazepam (Valium)

- At low doses, a moderate tranquilizer, causing sleepiness, drowsiness, confusion
- At high doses, results in excitement, disinhibition, severe sedation, and effects on respiration
- May produce a state of intoxication similar to that of alcohol, including slurred speech, disorientation
- Results in significant driving impairment - decreased divided attention, increase in lane travel, slowed reaction time, increased braking time, decreased eye-hand coordination, and impairment of tracking and vigilance

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## Harmful Intoxicants

- Common household items
- Purchased legally with little to no regulation
- No age restriction on purchase
- Inexpensive
- Produce a high
- Impair motor function
- Difficult to detect
- May result in an impaired driving conviction

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## The Process of an Impaired Driving Stop

- Officer observes inappropriate driving behavior
- Officer stops vehicle, engages driver in conversation, forms suspicion that the driver is impaired
- Standardized field sobriety tests
- Request for BAC sample
- Only when BAC level incompatible with observed impairment will the officer consider drugs other than alcohol
- Typically, if the BAC is at or above the legal limit, the investigation stops

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# Standardized Field Sobriety Tests

1981 – NHTSA develops standardized field sobriety tests (SFST)

Divided attention tests:

- ✓ Horizontal gaze nystagmus
- ✓ Walk-and-turn
- ✓ One-leg stand

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## SFST

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Listen to instructions

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Remember instructions

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Follow instructions

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Maintain attention to the task at hand

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Physically perform the task

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Perform more than one activity at once

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Not sensitive to alcohol only

Divided attention tests,  
not driving tests

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What if the BAC is inconsistent with the level of impairment?

## How Impaired Are You? Body Response at Rising BAC Levels



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## Drug Recognition Experts

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Police officers trained to recognize impairment in drivers under the influence of drugs other than, or in addition to alcohol

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Began in Los Angeles in the early 1970s

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Administered by NHTSA and the International Association of Chiefs of Police

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Now a nationally standardized DRE protocol

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Identifies seven different categories of drugs and the physical symptoms associated with each

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## Important Terms

Drug Recognition Expert – a law enforcement officer certified by the IACP

Drug Influence Evaluation – a formal *standardized* assessment of an impaired driving suspect performed by a DRE

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## Drug Influence Evaluation

- Based upon the principle that a given drug category will produce physiological responses in the body which can be observed and measured
- Not a test
- A method of collecting and interpreting evidence

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## Drug Categories

CNS depressants  
CNS stimulants  
Hallucinogens  
Dissociative anesthetics  
Narcotic analgesics  
Inhalants  
Cannabis

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## DRE Selection and Training

- ✓ Employed as a paid law enforcement officer
- ✓ Experience in preparing comprehensive reports and in providing detailed court testimony
- ✓ Completed training in and develop proficiency in SFST pre-DRE candidate acceptance (ARIDE required in NV)
- ✓ Phase I – 16 hour “pre-school”
- ✓ Phase II – 56 hour classroom program; examination
- ✓ Phase III – field training, satisfactorily complete a minimum of 12 DIE, with conclusions supported by forensic testing; examination and recommendation by two DREs

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# The DRE Protocol

A standardized and systematic method of examining a DUID suspect to determine:

1. Whether or not the suspect is impaired; if so,
2. Whether the impairment relates to drugs or a medical condition; and if drugs
3. What category or combination of categories of drugs are the likely cause of the impairment

Based on a complete set of observable signs and symptoms that are known to be reliable indicators of drug impairment

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# Standardized DRE 12-Step Protocol

- |                                   |                            |
|-----------------------------------|----------------------------|
| 1. Breath Test                    | 7. Dark Room Examination   |
| 2. Interview of Arresting Officer | Room Light                 |
| 3. Preliminary Exam               | Near Total Darkness        |
| First Pulse                       | Direct Light               |
| 4. Eye Examinations               | 8. Muscle Tone             |
| 5. Psychophysical Tests           | 9. Injection Sites         |
| 6. Vital Signs                    | Third Pulse                |
| Second Pulse                      | 10. Interrogation          |
|                                   | 11. Opinion of DRE         |
|                                   | 12. Toxicology Examination |

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**CRISIS INFLUENCE EVALUATION CHECKLIST**

1. Health History Form  
 2. Interview of Arresting Officer  
 3. Preliminary Examination  
 4. Eye Examination  
 5. Visual Acuity Test  
 6. Visual Evoked Test  
 7. Color Vision Test  
 8. Slit Lamp and Gonioscopy Exam  
 9. Goldmann Field Test  
 10. Optic Nerve Head Exam  
 11. Intraocular Pressure  
 12. Pupils  
 13. Extraocular Muscles  
 14. Ocular Motility  
 15. Ocular Alignment  
 16. Ocular Deviation  
 17. Ocular Tortus  
 18. Ocular Stare  
 19. Ocular Reflexes  
 20. Ocular Pain  
 21. Ocular Discharge  
 22. Ocular Trauma  
 23. Ocular Inflammation  
 24. Ocular Infection  
 25. Ocular Neoplasm  
 26. Ocular Degeneration  
 27. Ocular Malformation  
 28. Ocular Injury  
 29. Ocular Disease  
 30. Ocular Abnormality

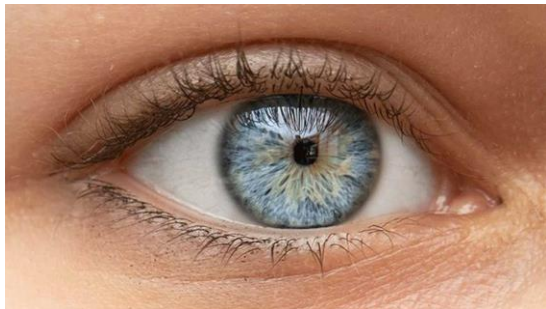
**RESULTS:** (If None, Put None)

**PUPILS:** (If None, Put None)  
 Right Eye: Size, Shape, Color, Reaction, Position, Range: 2.0-5.0mm  
 Left Eye: Size, Shape, Color, Reaction, Position, Range: 2.0-5.0mm  
 Anisocoria: Average: 0.5mm, Range: 0.0-0.5mm  
 Constriction: Average: 2.0mm, Range: 2.0-4.0mm

**BLOOD PRESSURE:** (If None, Put None)  
 Systolic: Average: 120mmHg, Range: 90-160mmHg  
 Diastolic: Average: 80mmHg, Range: 60-110mmHg

**BODY TEMPERATURE:** (If None, Put None)  
 Rectal: Average: 37.0°C, Range: 36.0-38.0°C  
 Axillary: Average: 36.5°C, Range: 35.5-37.5°C  
 Oral: Average: 37.0°C, Range: 36.0-38.0°C

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# The DRE Matrix

Indicators Consistent with Drug Categories

	CNS Depressants	CNS Stimulants	Hallucinogens	Dissociative Anesthetics	Narcotic Anesthetics	Inhalants	Cannabis
HRV	Present	None	Present	Present	None	Present	None
Vertical Gaze Nystagmus	Present (High Dose)	None	None	Present	None	Present (High Dose)	None
Lack of Convergence	Present	None	None	Present	None	Present (4)	Present
Pupil Size	Normal (3)	Dilated	Dilated	Normal	Constricted	Normal (4)	Dilated (5)
Reaction to Light	Slow	Slow	Normal (3)	Normal	Little or None Visible	Slow	Normal
Pulse Rate	Down (2)	Up	Up	Up	Down	Up	Up
Blood Pressure	Down	Up	Up	Up	Down	Up/Down (5)	Up
Body Temperature	Normal	Up	Up	Up	Down	Up/Down/ Normal	Normal
Muscle Tone	Flaccid	Rigid	Rigid	Rigid	Flaccid	Normal or Flaccid	Normal
General Indicators	Disorientation Droopy eyelids Droowiness Drunk-like behavior Slow, sluggish reactions Tired, slurred speech Uncoordinated Unusually weak	Anxiety Body tremors Dry mouth Euphoria Exaggerated reflexes Euphoric Eyelid tremors Giddling speech Increased alertness Incoherence Inflating Inability Ruddiness to the nasal area Restlessness Runny nose Talliative	Body tremors Dazed appearance Difficulty with speech Flashbacks Hallucinations Memory loss Nausea Paranoia Panic-like Pupillary dilation Poor articulation of words Spontaneous Uncoordinated NOTE: With LSD, disorientation may be observed (goose bumps, hair standing on end)	Blank stare Confusion Chemical odor (PCP) Cyclical behavior Difficulty with speech Disoriented Eyes Wide Open Hypertension Incoherence verbal Incontinence Increased gain Involuntary "Moon Walking" Noncommunicative Parasitting (PCP) Possibly violent Sensory distortions Slow, slurred speech Sweat Warm to touch W/Dry	Depressed reflexes Droopy eyelids Drowsiness Dry mouth Euphoric Facial flushing Inability to concentrate Nausea "On the roof" Pupillary marks Shakiness, ruddy speech Slow deliberate movements NOTE: Tolerant users exhibit relatively little preliminary impairment.	Bloodshot eyes Confusion Disoriented Flushed face Intense headaches Lack of muscle control Non-communicative Odor of substance Pupillary dilation Ruddiness of skin Slurred speech Uncoordinated Weakness Water eyes	Altered time/space perception Alteration in thought formation Body tremors Bloodshot eyes Disoriented Drowsiness Euphoric Impaired memory Increased appetite Lack of concentration Mood changes Odor of Marijuana Pupillary dilation Reduced inhibition Sedation
Duration of Effects	Ultra Short: A few minutes Short: Up to 5 hours Intermediate: 6-8 hours Long: 8-14 hours	Fastest: 5-30 minutes Medium/intermediate: Up to 12 hours	Duration varies widely from one hallucinogen to another: LSD: 10-12 hours Psilocybin: 2-8 hours	PCP onset: 1-5 minutes Peak Effects: 15-30 minutes Exhibits effects up to 8 hours onset: onset 15-30 min. Effects 3-6 hours	Rapid: 4-8 hours Up to 24 hours Others: Vary	5-8 hours for most volatile solvents Anesthetic gases and liquids – vary short duration	3-5 hours – exhibit and feel effects (impairment may last up to 24 hours, without awareness of effects)
Usual Methods of Administration	Injected (occasionally) Inhalation Oral	Inhalation Injected Oral Snorted	Inhalation Oral Snorted Transdermal	Injected Inhalation Oral Snorted Transdermal	Injected Inhalation Oral Snorted Transdermal	Inhalation	Oral Snorted Transdermal
Overdose Signs	Clonmy skin Coma Rapid, weak pulse Shallow breathing	Agitation Hallucinations	Intense heat "trip" Hyperthermia Convulsions	Stupor Seizures and convulsions	Cardiovascular collapse Coma Convulsions Slow, shallow breathing	Cardiac arrhythmias Respiratory distress Nausea/vomiting Risk of death	Excessive vomiting Fingering Acute anxiety ataxia Paranoia Psychotic episodes

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# Limitations

- A conclusion is never based on any one element of the evaluation, but instead on the totality of facts that emerge
- Err in favor of the subject
- Rules out medical conditions
- Records all observations, which are subject to peer review
- Observations confirmed by urine, blood or oral fluids
- Subject to cross-examination

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# The Texas Experience

- Two years experience as a Texas peace officer employed by a state, county or municipal law enforcement agency
- Completed NHTSA 24 hour SFST course
- Possess a reasonable background in impaired driving enforcement
- Possess a documented ability to complete thorough and accurate reports
- Recommendation of two current DREs
- Training
  - Three phases
    - DRE pre-school and DRE school (9 days)
    - DRE field certification
    - DRE examination
- Recertification every two years

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- 335 certified DREs in 2022
- 261,194 square miles of land in Texas
- 2,332 square miles per DRE per shift



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## *State v. Olenowski*

Special Master appointed to consider and decide whether DRE evidence has achieved general acceptance within the relevant scientific community and therefore satisfied the reliability standard of Evid. R. 702.

42 days of testimony

16 witnesses

300+ page final report

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## The Special Master's Report

1. The seven drug categories in the DRE matrix are consistent with comparable matrices used and generally accepted in the medical field
2. DREs can be and are adequately trained to competently perform all of the scientifically based steps in the DRE protocol and to reliably observe and report on the results in a manner that is comparable to the training and performance of individuals in the medical field, such as clinical technicians and EMTs

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## The *Olenowski* Legacy

Specially trained police officers who serve as DREs can be, and are adequately trained in those aspects of the protocol that are scientifically based; laypersons – not just police officers – are routinely trained to reliably make assessments and perform medical tasks and are thus enabled to reliably apply the protocol

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## Admissibility of DRE Testimony

The protocol is scientifically reliable; a DRE may testify as an expert witness regarding the administration and results of the protocol as applied to a particular defendant. While the protocol as a whole is not scientific, there is a sufficient scientific foundation for the protocol to be admissible under *Daubert*; many of the steps are non-scientific, such as the officer's observations and interview, but are reliable.

*New Mexico v. Aleman*, 145 N.M. 79 (2008)

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“Nothing contained in the protocol is a new invention,” and the protocol is “rather a compilation of tried and true procedures utilized by medical science and the law enforcement community in similar contexts for many years.”

*People v. Quinn*, 580 N.Y.S.3d 818 (1991)

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DRE officers “may not predict the specific level of drugs present in a suspect,” but may, when properly qualified, “express an opinion that a suspect’s behavior and physical attributes are or are not consistent with the behavioral and physical signs associated with certain categories of drugs.”

*State v. Baity*, 991 P.2d 1151 (Wash. 2000)

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## Admissibility in Texas

- The drug-recognition field is an experience- and training-based field
- Because this analysis is rooted in experience and training, as opposed to the rigors of the scientific method, the less-stringent soft-science requirements of reliability is applicable to drug-recognition-expert testimony

*Sanders v. Texas* (2020)(Unpublished)

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## *Richter v. Texas*, 482 S.W. 3d 388 (2015)

- The field of drug recognition is noted as a recognized field
- A trial court has great discretion in determining whether a witness possesses sufficient qualification to assist the jury as an expert on a specific topic in a particular case
- The experience of a DRE goes to the weight, but not the admissibility of the testimony

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## Contact Information

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