

Winter 2017

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Recommended Citation

Alice Kwak, *Medical Marijuana and Child Custody: The Need to Protect Patients and their Families from Discrimination*, 28 *Hastings Women's L. R.* 119 (2017).

Available at: <http://repository.uchastings.edu/hwlj/vol28/iss1/8>

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Medical Marijuana and Child Custody: The Need to Protect Patients and their Families from Discrimination

*Alice Kwak**

INTRODUCTION

Regulation of marijuana use in the United States is complicated. Marijuana is a controlled substance under federal law, and therefore an illegal drug.¹ In the last twenty years, however, twenty-four states² and the District of Columbia³ have legalized the medical use of marijuana for qualified patients. Some have gone further and legalized the recreational use of marijuana.⁴ These states' progressive marijuana laws reflect the American public's awareness of marijuana's medical value and their

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1. Amy Nordrum, *Why is Marijuana a Schedule I Drug?*, INT'L BUS. TIMES (Feb. 19, 2015, 1:33 PM), <http://www.ibtimes.com/why-marijuana-schedule-i-drug-1821426>.

2. The twenty-four states that have passed medical marijuana laws are: Alaska (Alaska Stat. §17.37.10 to 17.37.80), Arizona (Ariz. Rev. Stat. § 36-2801 to 36-2819), California (Cal. Health & Saf. Code § 11362.7 to 1362.83), Colorado (Colo. Rev. Stat. § 18 to 18-406.3), Connecticut (An Act Concerning the Palliative Use of Marijuana), Delaware (Senate Bill No. 17 (2011)), Georgia (House Bill 1 (2015)), Hawaii (Haw Rev. Stat. § 329-121 to 329-128), Illinois (House Bill 1 (2013)), Maine (Me. Rev. Stat. § tit. 22, 2421-2430), Maryland (Md. Code Ann., Crim. Law § 5-601(c)(3)(II)), Massachusetts (Law for the Humanitarian Medical Use of Marijuana), Michigan (Mich. Comp. Laws § 333.26421 to 333.26430), Minnesota (Minn. Stat. § 13.3806), Montana (Mont. Code Ann. § 50-46-1 to 50-46-103), Nevada (Nev. Rev. Stat. § 453A.010 to 453A.240), New Hampshire (House Bill 573 (2013)), New Jersey (Senate Bill 199 (2010)), New Mexico (N.M. Stat. Ann. § 26-2B-1 - 26-2B-7), New York (Compassionate Care Act (2014)), Oregon (Or. Rev. Stat. § 475.300 - 475.346), Rhode Island (6 R.I. Gen. Laws § 21-28.6-1 to 21-28.6-2), Vermont (Vt. Stat. Ann. tit. 18, § 4471- 4474d), and Washington (Wash. Rev. Code § 69.51A - 69.51A.901).

3. Washington D.C. (D.C. Code Ann. § 7-1671.01 - 7-1671.13).

4. States that have legalized recreational marijuana are: Alaska, Colorado, Oregon, Washington and the District of Columbia. Emily Gray Brosious, *At Least 20 States Could Vote on Marijuana Legalization in 2016*, SUN TIMES NETWORK (Feb. 19, 2016, 7:50 AM), <http://national.suntimes.com/national-world-news/7/72/2621877/20-states-to-vote-on-marijuana-legalization-2016-elections>.

growing acceptance of marijuana use.⁵ However, the conflict between federal and state law creates great uncertainty regarding any number of issues related to medical marijuana. This note addresses the issue for parents who may stand to lose child custody due to discrimination against the parent's status as a medical marijuana patient or provider for their children. Parents may be forced to choose between marijuana to alleviate health problems and the retention of custody of their children; in some cases, parents are being forced to choose between living with chronic, debilitating pain and potentially facing a child custody battle or loss of a child to the foster care system.

Seventy-five years of marijuana prohibition has built marijuana's negative reputation, and accordingly, its use by a parent has been considered a negative factor for judges when determining child custody cases. There is a strong presumption that one cannot use marijuana and be a fully functioning person, especially not an adequate parent. Since the enactment of medical marijuana statutes⁶ only a few states have specific anti-custody discrimination provisions. These provisions give courts guidance to not make custody determinations based on a parent's status as a medical marijuana patient alone because there is to be no presumption of neglect or child endangerment for such patients.⁷ In most states, there is no statutory language protecting medical marijuana patients from custody discrimination, so it is still unclear how the use of medical marijuana by parents should be considered in child custody cases. Trial court judges are granted broad discretion in determining matters of child custody, placement, and assessing the best interests of the child. Such judicial discretion, coupled with the lack of any specific guidance in most medical marijuana statutes regarding the effect on child custody, creates an enormous conflict for parents who are unsure if their use of physician-recommended marijuana will put them at risk of losing their children.

This note advocates the inclusion of anticustody discrimination provisions in the fourteen states plus the District of Columbia's medical marijuana statutes that currently remain silent on the issue of child

5. *Medical Marijuana Overview*, DRUG POLICY ALLIANCE, http://www.drugpolicy.org/docUploads/june4_actionpacket.pdf (last visited Oct. 25, 2016) ("More than 70% of voters support the right of patients to use marijuana with a doctor's recommendation — including substantial majorities of Democrats, Republicans, and Independents.").

6. *See supra* note 2.

7. The states with anticustody discrimination provisions in their medical marijuana statutes are: Arizona (ARIZ. REV. STAT. § 36-2813), Delaware (DEL. CODE ANN. Tit 16, § 4905A(b)), Hawaii (HAW. REV. STAT. § 329-125(b)), Illinois (410 ILL. COMP. STAT. § 130/40(b)), Maine (ME. REV. STAT. ANN. Tit. 22. § 2423-E(3)), Michigan (MICH. COMP. LAWS ANN. § 333.26424(4)(c)), Minnesota (MINN. STAT. ANN. § 152.32, subd. 3. para. (e)), New Hampshire (N.H. REV. STAT. ANN. §§ 126-X:1, 126-X:2), New York (N.Y. PUB. HEALTH § 3369(3)), and Washington (WASH. REV. CODE ANN. §§ 69.51A.120).

custody.⁸ All current and future states with medical marijuana statutes must protect medical marijuana patient-parents from custody discrimination. Without evidence of unreasonable danger to the safety of children, a parent using marijuana for legitimate medical reasons safely and in compliance with state laws should not be at risk of having his or her children removed from their home on the sole basis of their status as a medical marijuana patient. While little case law exists on this issue, the continuing legalization of marijuana indicates that the number of child custody cases involving removal of a child from the home due to a parent's medical marijuana use will grow.⁹ Thus, immediate reform of state statutes is crucial to preserve the spirit of the medical marijuana laws and to protect the rights of parents to use marijuana to treat medical conditions as authorized by state law.

Part I will briefly illustrate the history of medical marijuana. While disagreement exists, there is a significant, growing body of scientific and medical evidence as to marijuana's benefits. It will explain marijuana's status as an illegal drug under Schedule I of the Federal Controlled Substances Act, and will contrast federal law to the current state medical marijuana laws.

Part II will focus on child custody, specifically on the standards for determining the fitness of the parent and the evolution of the standards used by courts to determine custody. The basis in law for custody decision-making has evolved from a paternal presumption to a maternal presumption to the currently prevailing gender-neutral standard, prioritizing the best interest of the child. It will explore the positives and negatives of the standard's inherent broad discretion granted to the judge in interpreting these standards and the factors typically taken into consideration when deciding custody issues.

Part III will present the intersection of medical marijuana use by parents and the potential risk of losing child custody. In short, the conflict between the federal and state laws, and lack of statutory guidance leaves parent-patients legally uncertain about what choices are required, and afraid of losing their children. While most state medical marijuana statutes generally protect patients from criminal charges,¹⁰ they fail to provide parents protection against losing their children under family law doctrine. Medical marijuana patients who have legitimate medical conditions and

8. See note 7. Only ten out of twenty-four states and Washington D.C. have anticustody discrimination provisions.

9. Erwin Chemerinsky, Jolene Forman, Allen Hopper & Sam Kamin, *Cooperative Federalism & Marijuana Regulation*, 62 UCLA L. REV. 74, at 99–100 (2015).

10. *Drug War Statistics*, DRUG POLICY ALLIANCE, <http://www.drugpolicy.org/drug-war-statistics> (last visited Feb. 5, 2016) (“Number of states that have decriminalized marijuana by eliminating criminal penalties for simple possession of small amounts for personal use: 20.”).

who adhere to state marijuana laws are at risk of having their children removed even if they are perfectly fit to care for their children. Current cases illustrating this problem will be examined.

Finally, Part IV argues the need for all state legislatures to include specific anticustody discrimination provisions in their medical marijuana statutes. It will highlight the state statutes with such provisions. Out of the twenty-four states plus the District of Columbia with legalized medical marijuana use, more than half fail to address child custody matters in their statutes. For those state statutes that remain silent on medical marijuana use in child custody matters, legislative reform is needed to protect parents from discrimination in child custody cases due to their legitimate use of marijuana, when it is a state-sanctioned, medical remedy. These provisions should direct courts not to make custody decisions based on the parent's legal status as a medical marijuana user alone, and instead focus on additional probative circumstances in a particular case. Parents-patients should be afforded discrimination protection under state law and courts need statutory guidance to address such issues.

PART I. MARIJUANA IS COMPLICATED

A. A BRIEF HISTORY OF MEDICAL MARIJUANA

Marijuana has been “part of humanity’s medicine chest for almost as long as history has been recorded.”¹¹ The extensive history of medical marijuana use starts in 2737 B.C. China, where Emperor Shen Neng, the father of Chinese medicine, introduced the healing powers of marijuana to the Chinese people.¹² Marijuana was prescribed to treat many conditions, including, gout, malaria, beriberi, rheumatism, and memory issues.¹³ Accordingly, the first pharmacopoeia of the East, based on Shen Neng’s teachings, listed marijuana as a medicine.¹⁴ News of marijuana’s medical value eventually spread to India and by 1400 B.C. marijuana was listed in the sacred Indian text as effective for relieving stress, fevers, and inflammation of the mucous membranes.¹⁵

Continuing its journey around the globe, marijuana reached ancient Rome, where Pliny the Elder suggested its use as a painkiller and a Roman physician recommended using the juice of the marijuana seed for earaches.¹⁶ Evidence suggests marijuana was used to ease pain and

11. *About Marijuana*, NORML: WORKING TO REFORM MARIJUANA LAWS, <http://norml.org/marijuana> (last visited Feb. 2, 2016).

12. MITCH EARLEYWINE, *UNDERSTANDING MARIJUANA: A NEW LOOK AT THE SCIENTIFIC EVIDENCE* 9–10 (Oxford U. Press 2002).

13. *Id.*

14. *Id.* at 11.

15. *Id.*

16. *Id.*

increase uterine contractions during childbirth in Jerusalem.¹⁷ By the twelfth century, marijuana found its way to Africa where different tribes had different uses for it.¹⁸ The Hottentots prescribed it for snakebites, the Rhodesia used it to treat malaria, and in South Africa, it was used to treat asthma.¹⁹ Numerous European publications in the 1500s mentioned marijuana, and it received its scientific name, *Cannabis sativa*, by a Swedish naturalist.²⁰

When the Spanish first brought marijuana to the Americas in 1545, it was primarily grown for its commercial use as hemp.²¹ As a medical product, it was not popular and rarely prescribed by doctors.²² The work of Irish physician, William O'Shaughnessy, is believed to have changed the fate of medical marijuana. Due to O'Shaughnessy's successful medical applications of marijuana in 1833, the demand and interest in medical marijuana increased.²³ O'Shaughnessy confirmed marijuana's medical value, finding that marijuana eased pain, nausea and spasticity of conditions like epilepsy and rabies.²⁴ Finally in 1850, marijuana was added to the United States Pharmacopeia and in 1868, the United States Dispensary, an unofficial publication providing an international listing of existing and discontinued drugs, claimed an extract of marijuana soaked in alcohol improved appetite, sexual interest, mental disorders, insomnia, and more.²⁵ By the early 1900s, marijuana's medical value was generally acknowledged and drug companies in Europe and America began marketing marijuana products for a variety of symptoms and pharmaceutical preparations were readily available.²⁶

Despite the acknowledgement of marijuana's medical value in the nineteenth century, in the following century marijuana's medical use decreased. Still, marijuana use remained popular for a different purpose. After the Mexican Revolution of 1910, Mexican immigrants introduced the recreational use of marijuana to American culture.²⁷ Marijuana quickly became "associated with the immigrants, and the fear and prejudice against the Spanish-speaking newcomers became associated with marijuana."²⁸ The high unemployment rates of the Great Depression increased "public

17. *Id.*

18. EARLEYWINE, *supra* note 12, at 12.

19. *Id.*

20. *Id.*

21. *History of Marijuana*, NARCONON INT'L, <http://www.narconon.org/drug-information/marijuana-history.html> (last visited Jan. 29, 2016).

22. EARLEYWINE, *supra* note 12, at 13.

23. *Id.*

24. *Id.*

25. *Id.*

26. *Id.*

27. *Marijuana Timeline, Busted: America's War on Marijuana*, PBS, <http://www.pbs.org/wgbh/pages/frontline/shows/dope/etc/cron.html> (last visited Jan. 29, 2016).

28. *Id.*

resentment and fear of Mexican immigrants, escalating public and governmental concern about the problems of marijuana.”²⁹ Marijuana became a hot topic of conversation for journalists, politicians, police, and middle-class readers,³⁰ and through media sensationalism, marijuana was further stigmatized and associated with violence, drug abuse, and insanity.³¹ Marijuana’s negative association with ethnic minorities and the lower class, combined with its growing reputation as a potentially dangerous drug, fueled America’s war on marijuana.³²

By 1931, marijuana was outlawed by twenty-nine states.³³ On the federal level, Harry J. Anslinger, the first Commissioner of the Federal Bureau of Narcotics (“FBN”), headed the “reefer madness” campaign, using “racist language and propaganda to position marijuana as the nation’s most dangerous drug.”³⁴ While it was not this work of Anslinger, alone, that created “the myth of demon cannabis . . . he breathed such horrifying life into it, shaping the public’s perception of marijuana for decades to come.”³⁵ Accordingly, Congress imposed strict restrictions on marijuana sales and prescriptions by passing the Marijuana Tax Act of 1937.³⁶ In 1942, against the recommendation of the American Medical Association, marijuana was removed from the United States Pharmacopeia, where it was originally listed for its medical value.³⁷

Despite this historical push against marijuana, today, marijuana is the “most commonly used illicit drug in the United States.”³⁸ Nearly 5 million people reported using marijuana on a daily or almost daily period basis over a year,³⁹ and almost half of the population has tried marijuana.⁴⁰ There is no denying of marijuana’s continued relevance and growth in

29. *Id.*

30. Stephen Siff, *The Illegalization of Marijuana: A Brief History*, ORIGINS: CURRENT EVENTS IN HISTORICAL PERSPECTIVE (May 2014), <http://origins.osu.edu/article/illegalization-marijuana-brief-history>.

31. *Id.*

32. Adam Rathge, *Pondering Pot: Marijuana’s History and the Future of the War on Drugs*, THE AMERICAN HISTORIAN, <http://tah.oah.org/issue-5/pondering-pot/> (last visited Jan. 29, 2016).

33. *Id.*

34. *Id.*

35. Ruth C. Stern & J. Herbie DiFonzo, *The End of the Red Queen’s Race: Medical Marijuana in the New Century*, 27 QUINNIPIAC L. REV. 673, 682 (2009).

36. EARLEYWINE, *supra* note 12, at 14.

37. *Id.*

38. *Answers to Frequently Asked Questions about Marijuana*, OFFICE OF NATIONAL DRUG CONTROL POLICY, <https://www.whitehouse.gov/ondcp/frequently-asked-questions-and-facts-about-marijuana> (last visited Feb. 5, 2016) (answering the question “What are the trends in marijuana use in the United States?”).

39. *Id.*

40. *In Debate Over Legalizing Marijuana, Disagreement Over Drug’s Dangers, In Their Own Words: Supporters and Opponents of Legalization*, PEW RESEARCH CENTER (Apr. 14, 2015), <http://www.people-press.org/2015/04/14/in-debate-over-legalizing-marijuana-disagreement-over-drugs-dangers/#survey-report> (“49% say they have ever tried marijuana”).

American history. For many reasons, marijuana is a controversial matter. On one hand, prohibition and popular awareness of marijuana stems from decades of unscientific,⁴¹ paranoid and even racist government war-on-drugs propaganda.⁴² As a result, many take the side of the federal government, advocating that marijuana is rightfully listed under Schedule I and should remain under the most stringent regulations. Organizations such as Citizens Against Legalizing Marijuana (“CALM”), Smart Approaches to Marijuana (“SAM”), and Parents Opposed to Pot, are just some of the few arguing against medical and recreational marijuana legalization.⁴³ On the other hand, the pro-marijuana movement has proved fruitful as many individual states began to relax laws by decriminalizing and legalizing medical marijuana, legalizing recreational marijuana, or some combination of both.⁴⁴

The status of marijuana has been ever changing in the United States. After years of prohibition, marijuana acceptance is rising. It is imperative for the American people to continue to not only tolerate, but also understand the value of marijuana and reject the dated stereotypes and negative associations with its controlled use. Marijuana seems to be regaining its status as a resource to be used and cultivated for its medicinal properties, just as it was in the nineteenth century. However, in regards to marijuana’s relationship with the justice system and federal law, there is much progress to be made.

B. MARIJUANA AND THE FEDERAL PROHIBITION

Under the Controlled Substances Act (“CSA”), marijuana is federally prohibited.⁴⁵ The CSA, Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, is a federal drug statute passed by Congress in hopes of remedying the country’s drug problem by regulating the manufacturing, use and distribution of drugs and other substances,

41. Sanjay Gupta, *Why I Changed My Mind on Weed*, CNN (Aug. 8, 2013, 8:44 PM), <http://www.cnn.com/2013/08/08/health/gupta-changed-mind-marijuana/> (explaining how he mistakenly believed there was scientific proof backing marijuana’s status as a schedule I substance and that the Drug Enforcement Agency was wrong to claim marijuana had a high potential for abuse and no acceptable medicinal use).

42. Maia Szalavitz, *Don’t Believe The (Marijuana) Hype*, THEFIX (Jan. 13, 2014), <https://www.thefix.com/content/Maia-Szalavitz-pot-addiction-health-2100> (stating that over the last 40 years, the government has spent billions of dollars on advertising campaigns to stop drug use and while they were often ineffective at preventing use, they seemed to work at clouding perception).

43. Jason Gray, *Marijuana Foes: 10 Organizations That Oppose Legalization of Pot*, NEWSMAX (Mar. 31, 2015), www.newsmax.com/FastFeatures/marijuana-legalization-opposition-organizations/2015/03/31/id/635535/.

44. See notes 2-5 for list of states with such statutes.

45. 21 U.S.C. § 812 (2012) (listed under Schedule I (c) Hallucinogenic Substances (10 “Marihuana”).

except as authorized by the CSA.⁴⁶ The legislation categorizes drugs into five Schedules or classifications, with varying qualifications for each Schedule.⁴⁷ By the recommendation of Assistant Secretary of Health, Roger E. Egeberg, marijuana was placed in the Schedule I category.⁴⁸ As indicated by his statement acknowledging a “considerable void in our knowledge of the plant and the effects,” Egeberg intended this placement to be temporary.⁴⁹ Egeberg recommended “marihuana be retained within schedule I at least until the completion of certain studies now underway to resolve the issue.”⁵⁰ To date, marijuana has been maintained as a Schedule I drug for nearly fourty-five years.⁵¹

Much opposition exists as to the harsh classification of marijuana in the CSA,⁵² as Schedule I is reserved for the most dangerous drugs, subjected to the most stringent regulations.⁵³ Three findings are required for a drug to qualify as Schedule I: a high potential for abuse, no currently accepted medical use in treatment in the United States, and a lack of accepted safety for use of the drug under medical supervision.⁵⁴ Marijuana is listed in this most restrictive category among other drugs, such as heroin and ecstasy. Unlike Schedule II-V drugs, Schedule I drugs cannot be prescribed by doctors under federal law.⁵⁵ Despite the growing number of health and scientific organizations, and high-profile doctors who support the medical use of marijuana,⁵⁶ the CSA continues to deny the medical value of

46. *Marijuana and the Controlled Substances Act: A Schedule I Narcotic?*, TRUTHONPOT.COM (Nov. 6, 2012), <http://www.truthonpot.com/2012/11/06/marijuana-and-the-controlled-substances-act-a-schedule-i-narcotic/>.

47. 21 U.S.C. § 812.

48. Gupta, *supra* note 41.

49. *Id.*

50. H.R. REP. NO. 91-1444, at 4629 (1970).

51. Gupta, *supra* note 41.

52. See Ben Adlin, *FDA Weighs in on Rescheduling Cannabis*, LEAFLY (Dec. 28, 2015), <https://www.leafly.com/news/headlines/fda-weighs-in-on-rescheduling-cannabis> (listing various failed efforts to reschedule marijuana); See also Jon Gettman, *Remove Marijuana from the Controlled Substances Act*, HIGH TIMES (Apr. 9, 2014), <http://www.hightimes.com/read/remove-marijuana-controlled-substances-act> (“This author, along with HIGH TIMES and other supporters, filed legal papers in 1995 and 2001 to compel the federal government to reschedule marijuana.”); See also Matt Smith, *states say it’s time to rethink medical marijuana*, CNN (Jan. 1, 2012, 4:13 PM), <http://www.cnn.com/2012/01/01/us/medical-marijuana/> (“Medical marijuana advocates, including the states that have petitioned the agency, say it should be listed under Schedule II, comparing it to other prescription painkillers that have a high potential for abuse.”).

53. *Marijuana and the Controlled Substances Act: A Schedule I Narcotic?*, *supra* note 46.

54. 21 U.S.C. § 812.

55. *Federal Marijuana Law*, AMERICANS FOR SAFE ACCESS: ADVANCING LEGAL MEDICAL MARIJUANA THERAPEUTICS AND RESEARCH, http://www.safeaccessnow.org/federal_marijuana_law (last visited Feb. 2, 2016).

56. See Matt Ferner, *U.S. Surgeon General Vivek Murthy Says Marijuana ‘Can Be Helpful’ For Some Medical Conditions*, THE HUFFINGTON POST (Feb. 4, 2015, 1:20 PM), http://www.huffingtonpost.com/2015/02/04/vivek-murthy-marijuana_n_6614226.html?utm

marijuana.⁵⁷ Thus, one may be criminalized for marijuana related activity, under federal law, even in the face of permissive state law.⁵⁸

C. STATES AND THE LEGALIZATION OF MARIJUANA

Notwithstanding the federal government's prohibition against the cultivation, sale, possession, and use of marijuana, attitudes about marijuana have fluctuated in the United States.

In the last few years, there has been a rapid shift of public opinion and the majority of Americans now favor the legalization of marijuana.⁵⁹ California was the first state to act on these sentiments by approving Proposition 215, the Compassionate Use Act of 1996, the first medical marijuana ballot initiative passed to legalize medical marijuana.⁶⁰ Despite the federal government threatening criminal prosecution to anyone who violated federal drug laws, in reaction to California's rebellion against the federal marijuana prohibition, other states followed the pioneer state's footsteps.⁶¹ Currently, twenty-four states and the District of Columbia allow qualified patients the opportunity to treat a variety of medical conditions and relieve pain with marijuana.⁶² These states also protect

⁵⁷ *hp_ref=tw*; E.g. Dr. Sanjay Gupta, *Dr. Sanjay Gupta: It's time for a Medical Marijuana Revolution*, CNN (Apr. 20, 2015, 9:27 AM), <http://www.cnn.com/2015/04/16/opinions/medical-marijuana-revolution-sanjay-gupta/>; *Health Endorsements*, NORML: WORKING TO REFORM MARIJUANA LAWS, <http://norml.org/marijuana/health-organizations-endorsements> (last accessed Feb. 2, 2016) (listing more than 60 U.S. and international health organizations).

⁵⁸ See 21 U.S.C. § 812(c); see, e.g. *United States v. Oakland Cannabis Buyers' Coop.*, 532 U.S. 483 (2001) (holding that despite the lack of an explicit provision, there is no medical necessity exception to CSA's marijuana prohibition because Congress had determined marijuana had no medical value).

⁵⁹ See *Oakland Cannabis Buyer's Coop.*, 532 U.S. at 483, 489 (no medical necessity defense to the CSA); *Gonzales v. Raich*, 545 U.S. 1, 23 (2005) (holding that under the Commerce Clause, the federal government maintains the authority to criminalize the cultivation of a small amount of medical marijuana).

⁶⁰ *In Debate Over Legalizing Marijuana, Disagreement Over Drug's Dangers*, PEW RESEARCH CENTER (Apr. 14, 2015), <http://www.people-press.org/2015/04/14/in-debate-over-legalizing-marijuana-disagreement-over-drugs-dangers/#survey-report> (2015 survey finds 53% of Americans favor the legal use of marijuana); Jeffrey M. Jones, *In U.S., 58% Back Legal Marijuana Use*, GALLUP (Oct. 21, 2015), <http://www.gallup.com/poll/186260/back-legal-marijuana.aspx> (58% of Americans favor legal use of marijuana).

⁶¹ Compassionate Use Act, Prop. 215 (codified at CAL. HEALTH & SAFETY CODE § 11362.5); see Stephen Gutwillig, *Medical Marijuana in California: A History*, L.A. TIMES (Mar. 6, 2009), <http://www.latimes.com/health/la-oew-gutwillig-impler6-2009mar06-story.html> (explaining that 56% of Californian voters supported Proposition 215 in 1996 and now about 75% support medical marijuana).

⁶² Gutwillig, *supra* note 60 (stating that immediately following Prop. 215's passage, the federal government publicly threatened to revoke the Drug Enforcement Administration license of any physician who prescribed marijuana).

⁶³ *Marijuana Resource Center: State Laws Related to Marijuana*, OFFICE OF NATIONAL DRUG CONTROL POLICY, <http://www.whitehouse.gov/ondcp/state-laws-related-to-marijuana> (last accessed Feb. 11, 2016); MARIJUANA POLICY PROJECT, *State-By-State Medical Marijuana Laws: How to Remove the Threat of Arrest* 10 (2015), <https://www.mpp.org/>

physicians from liability for prescribing marijuana for treatment.⁶³ Four of those states and the District of Columbia have gone beyond the boundaries of medical marijuana and legalized the recreational use of marijuana for those age twenty-one and over.⁶⁴

Each state similarly specifies qualifying medical conditions for medical marijuana use, allows patients to use marijuana as prescribed by a physician, prohibits the use of medical marijuana in certain settings,⁶⁵ and protects patients from criminal penalties for using marijuana for their designated medical purpose.⁶⁶ Every state has a different list of medical conditions that qualify a patient for medical marijuana use.⁶⁷ There is no consensus among states in the amount of marijuana a patient can possess, whether patients are authorized to cultivate their own marijuana for medical use, or whether minors may use medical marijuana.⁶⁸

issues/medical-marijuana/state-by-state-medical-marijuana-laws/state-by-state-medical-marijuana-laws-report/ (listing the states who have effective medical marijuana laws: Alaska, Arizona, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Montana, Minnesota, Nevada, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, Vermont, Washington state, and the District of Columbia).

63. *State-By-State Medical Marijuana Laws Report 2015*, *supra* note 62.

64. Liz Rowley, *Where is Marijuana Legal in the United States? List of Recreational and Medicinal States*, NEWS.MIC (Oct. 5, 2015), <http://mic.com/articles/126303/where-is-marijuana-legal-in-the-united-states-list-of-recreational-and-medicinal-states#.KiGzz7eqn>; *Recreational Marijuana: Frequently Asked Questions*, Oregon.gov, http://www.oregon.gov/olcc/marijuana/pages/frequently-asked-questions.aspx#Personal_Use (last accessed Feb. 11, 2016) (“[A]nyone at least 21 years of age can consume recreational marijuana in Oregon.”); *Get the Facts About Marijuana*, Alaska Dept. of Health and Soc. Serv., <http://dhss.alaska.gov/dph/Director/Pages/marijuana/law.aspx> (last accessed Feb. 11, 2016) (“You must be 21 years old to use marijuana products.”); *Marijuana Laws in Colorado*, Colo. Pot Guide, <https://www.coloradopotguide.com/marijuana-laws-in-colorado/> (last accessed Feb. 11, 2016) (“[A]s long as you are 21 years or older, you have a constitutional right to possess and consume marijuana in Colorado.”); *Medical Marijuana Fact Sheet*, Wash. State Liquor and Cannabis Board, www.liq.wa.gov/mj2015/fact-sheet (last accessed Feb. 11, 2016) (stating that individuals age 21 and older are legally authorized to possess and use marijuana within limits); *Initiative 71 and DC's Marijuana Laws Questions and Answers*, Gov't of the D.C. Muriel Bowser, Mayor, dcmj.org/wp-content/uploads/2015/02/I71QA.pdf (last accessed Feb. 11, 2016) (stating it is legal for adults 21 years of age or older to use, possess, grown and transfer marijuana).

65. Duke Chen & James Orlando, *Comparison of Medical Marijuana Programs*, OLR RESEARCH REPORT (July 15, 2013) <https://www.cga.ct.gov/2013/rpt/2013-R-0271.htm> (listing the similarities between states' medical marijuana programs).

66. *State Medical Marijuana Laws*, NAT'L CONF. OF STATE LEGIS. (Jan. 25, 2016), www.ncls.org/research/health/state-medical-marijuana-laws.aspx (“States with medical marijuana laws generally have some form of patient registry, which may provide some protection against arrest for possession up to a certain amount of marijuana for personal medical use.”).

67. *Marijuana Resource Center: State Laws Related to Marijuana*, *supra* note 62.

68. CAL. HEALTH & SAFETY CODE § 11362.72(a)(1) (2016) (California authorizes medical marijuana use for minors as long as the county health department contacts the parent, guardian, or other person with legal authority to make medical decisions, to verify

D. THE CONFLICT BETWEEN THE FEDERAL PROHIBITION AND STATE LEGALIZATION

As a result of the major discrepancy between federal and state marijuana laws, courthouse doors have swung open for ensuing litigation. In 2005, the United States Supreme Court granted certiorari to a petition highlighting the conflict between the federal prohibition of marijuana and the state legalization of medical marijuana. In the landmark case of *Gonzalez v. Raich*, the Court held that Congress had power under the Commerce Clause to prohibit the local cultivation and use of marijuana in compliance with state law.⁶⁹ This holding was controversial because it authorized Congress to regulate a purely intrastate activity related to a “locally cultivated product.”⁷⁰ To alleviate pain and suffering from serious medical conditions, Angel Raich and Diane Monson cultivated marijuana plants in their homes for their own personal use in compliance with California’s Compassionate Use Act, which allows limited use of marijuana for qualified patients like Raich and Monson.⁷¹ While the authority to regulate and criminalize drug use is within the scope of the state governments, the Court agreed since the manufacture, local distribution, and possession of marijuana at the state level could have a substantial effect on interstate commerce, it was appropriate for Congress to decline to differentiate between controlled substances manufactured and distributed within a state and those flowing through interstate commerce.⁷² Thus, the CSA was a “valid exercise of federal power” and stood constitutionally supreme over state laws, despite states’ authorization of medical marijuana use.⁷³

However, under President Barack Obama’s administration, the federal government has relaxed its policy on federal prosecution of marijuana related crimes. Although marijuana policy is not a priority for Congress or President Obama,⁷⁴ the President has spoken about the topic numerous times, specifically stating, “not only do I think carefully prescribed medical use of marijuana may in fact be appropriate and we should follow the science as opposed to ideology on this issue . . . the more we treat some of these issues related to drug abuse from a public health model and not just

the minor’s application.); *Cf.* Conn. Gen. Stat. § 21a-408(10) (2016) (“Qualifying patient means a person who is eighteen years of age or older...”).

69. *Gonzalez v. Raich*, 545 U.S. 1 (2005).

70. *Id.* at 32–33.

71. *Id.* at 6–7.

72. *Id.* at 16–17 (Scalia, J., concurring).

73. *Id.* at 9.

74. Sean Williams, *President Obama Crushes the Marijuana Movement With 15 Words*, THE MOTLEY FOOL (Apr. 19, 2015), www.fool.com/investing/general/2015/04/19/president-obama-crushes-the-marijuana-movement-wit.aspx.

from an incarceration model, the better off we're going to be."⁷⁵ Further, he had previously stated that he views marijuana as no "more dangerous than alcohol."⁷⁶ On August 29, 2013, the Department of Justice ("DOJ"), the agency committed to enforcing the CSA, issued the latest of a series of memos guiding federal prosecutors on marijuana enforcement.⁷⁷ This memo updated the DOJ's policy "in light of recent state ballot initiatives that legalize, under state law, the possession of small amounts of marijuana and provide for the regulation of production, processing, and sale."⁷⁸

The DOJ listed marijuana enforcement priorities, including preventing the distribution of marijuana to minors, preventing gangs and cartels from financially benefiting from the sale of marijuana, and preventing violence and use of firearms in marijuana related activity.⁷⁹ These priorities will guide the enforcement of the CSA on a case-by-case basis, so resources will not be focused on individuals who are in "unambiguous compliance with existing state laws."⁸⁰ As long as the states with legalized production, distribution and possession of marijuana establish strict regulatory schemes protecting those priorities listed,⁸¹ the federal government will defer its right to challenge those states' permissive marijuana statutes and will only interfere if the prioritized circumstances are concerned.⁸² The DOJ found as a matter of policy that state-authorized marijuana activities were less likely to threaten the enumerated federal priorities than unauthorized activities.⁸³ It is important to note this diluted marijuana enforcement policy can change under a new president and regardless of Obama's

75. Christopher Hooton, *Obama lends support to marijuana legislation: 'We Should Follow the Science Not the Ideology'*, INDEPENDENT (Apr. 20, 2015), www.independent.co.uk/news/world/americas/obama-lends-support-to-marijuana-legislation-we-should-follow-the-science-not-the-ideology-10189504.html.

76. Hooton, *supra* note 75.

77. Memorandum from David W. Ogden, Deputy Attorney General, Investigations and Prosecutions in States Authorizing the Medical Use of Marijuana (Oct. 19, 2009), <http://www.justice.gov/opa/blog/memorandum-selected-united-state-attorneys-investigations-and-prosecutions-states>; Memorandum from James M. Cole, Deputy Attorney General, Guidance Regarding the Ogden Memo in Jurisdictions Seeking to Authorize Marijuana for Medical Use (June 29, 2011), <http://www.justice.gov/sites/default/files/oip/legacy/2014/07/23/dag-guidance-2011-for-medical-marijuana-use.pdf>; Memorandum from James M. Cole, Deputy Attorney General, Guidance Regarding Marijuana Enforcement (Aug. 29, 2013), <http://www.justice.gov/iso/opa/resources/3052013829132756857467.pdf>.

78. Guidance Regarding Marijuana Enforcement, *supra* note 77, at 1.

79. *Id.*

80. Ariane de Vogue, *Obama Admin Weighs In on Legalized Marijuana at the Supreme Court*, CNN (Dec. 16, 2015, 9:59 PM), <http://www.cnn.com/2015/12/16/politics/supreme-court-marijuana-colorado-obama/> (quoting DOJ's 2013 memorandum).

81. *Id.*

82. *Id.*

83. Blaine I. Green & Emily M. Burkett, *Much Ado About Doing Nothing: DOJ's Latest Memorandum Cracks Open Door to Marijuana Development on Tribal Lands*, PILLSBURY WINTHROP SHAW PITTMAN LLP (Apr. 21, 2015), <http://www.pillsburylaw.com/siteFiles/Publications/AlertApril2015IndianLawMuchAdoAboutDoingNothing.pdf>.

administration's relaxed approach, the status of marijuana as a Schedule I, federally prohibited drug remains unaffected. Although these changes to federal policy have only begun more than a decade after first state passed modern medical marijuana laws, they are strong indications of the continuing evolution of marijuana.

In the words of Dr. Sanjay Gupta, CNN's Chief Medical Correspondent, "[Marijuana] doesn't have a high potential for abuse, and there are very legitimate medical applications. In fact, sometimes marijuana is the only thing that works."⁸⁴ This was the case for Charlotte Figi, a child in Colorado who, by age three, was having 300 seizures a week and had lost her ability to walk, talk and eat due to Dravet Syndrome.⁸⁵ None of the seven addictive and intense medications she was prescribed successfully alleviated the seizures.⁸⁶ After introducing medical marijuana, through the form of cannabis oil, into her treatment, Charlotte has experienced tremendous improvement.⁸⁷ With her first dose, Charlotte's seizures stopped for seven days.⁸⁸ Today, she has only two to three seizures per month and is "getting her life back one day at a time."⁸⁹

PART II. CHILD CUSTODY AND THE COURTS

A. THE EVOLUTION OF THE BEST INTEREST OF THE CHILD STANDARD

Children were once considered the property of their father and valued, at least partially, for their contribution to the labor force.⁹⁰ Early laws in this country "principally enforced the labor relationship and paid little heed to their need for nurturing."⁹¹ Fathers had a property right to their children and thus, had rights to the association and labor of their children.⁹² Since colonial America, the legal and social status of children has improved dramatically. Courts rejected claims of parental property rights to their children, and starting in the late nineteenth century, child custody disputes were resolved based on the interests of the children.⁹³ This substantial departure from earlier custody standards, which focused on the importance of the rights of the parents rather than that of children, reflected the

84. Gupta, *supra* note 41.

85. Sandra Young, *Marijuana stops child's severe seizures*, CNN (Aug. 7, 2013, 4:51 PM), www.cnn.com/2013/08/07/health/charlotte-child-medical-marijuana/index.html.

86. *Id.*

87. *Id.*

88. *Id.*

89. *Id.*

90. Kathleen Kelley Reardon & Christopher T. Noblet, *CHILDHOOD DENIED: ENDING THE NIGHTMARE OF CHILD ABUSE AND NEGLECT* 83, 85–87 (SAGE Publications, Inc. 2009).

91. *Id.* at 87.

92. *Id.* at 86.

93. Daniel A. Krauss & Bruce D. Sales, *Legal Standards, Expertise, and Experts in the Resolution of Contested Child Custody Cases*, 6 *PSYCHOL. PUB. POL'Y. AND L.* 843, 846 (Dec. 2000).

changes in family structures, social roles, and society values in the United States.

Although the idea of children as property has been rejected, child custody issues continued to be settled on gender based assumptions and stereotypes until the 1970s.⁹⁴ Rather than the earlier, male centered perspective, the increasing concern for the welfare of the child became indistinguishable from the assumption that a female's nurturing nature made her better suited to care for children.⁹⁵ Thus, it was believed it was in the best interest of a young child to be under the custody of the mother.⁹⁶ Known as the tender years doctrine, this standard only allowed a father to gain custody of his children if he could prove to the court the mother was unfit, rebutting the legal presumption favoring the mother.⁹⁷ More often than not, the mother was awarded custody.⁹⁸

As the social culture in the U.S. changed, most states abandoned the maternal presumption and custody preference in favor of a gender-neutral, best interest of the child standard.⁹⁹ The Uniform Marriage and Divorce Act ("UMDA") supported this sentiment by creating child custody determination criteria, indicating for the first time, child custody decisions were to be made based on the needs and interests of the child and the facts of a particular case, rather than based on any gendered presumptions or the rights of the parents.¹⁰⁰ The UMDA instructs courts to "determine custody in accordance with the best interest of the child," and lists the following five relevant factors it may consider:

- (1) the wishes of the child's parent or parents as to his custody;
- (2) the wishes of the child as to his custodian;
- (3) the interaction and interrelationship of the child with his parent or parents, his siblings, and any other person who may significantly affect the child's best

94. Krauss & Sales, *supra* note 93.

95. *Id.*

96. Ramsay Laing Klaff, *The Tender Years Doctrine: A Defense*, 70 CALIF. L. REV. 335, 342 (Mar. 1982).

97. *Id.*

98. *Id.*

99. Joan B. Kelly, *The Determination of Child Custody*, 4 THE FUTURE OF CHILDREN, no. 1, Spring 1994, at 121, 122 (1994), available at https://www.princeton.edu/futureofchildren/publications/docs/04_01_07.pdf ("Spurred on by fathers' claims of sex discrimination in custody decisions, constitutional concerns for equal protection, the feminist movement, and the entry of large numbers of women into the work force, which weakened the concept of a primary maternal caretaker, most states abandoned the maternal presumption by the mid-1970s in favor of gender-neutral laws." citations omitted); Richard A. Warshak, *Parenting By The Clock: The Best-Interest-Of-The-Child Standard, Judicial Discretion, And The American Law Institute's "Approximation Rule"*, 41 U. BALT. L. REV. 83, 92 (2011) (showing that general neutrality is debatable as fathers' rights advocates assert the maternal preference still exists, while women's advocates claim judges are biased in favor of fathers).

100. Kelly, *supra* note 99.

interest; (4) the child's adjustment to his home, school, and community; and (5) the mental and physical health of all individuals involved.¹⁰¹

The UMDA standard lacks more specific guidance for courts to handle custody issues. It is silent on how much weight to give each factor and whether to focus on the past, present, or future of the child. It merely states "trial court must look to a variety of factors" and "judges need not be limited to the factors specified," without hinting at what other factors may be of importance.¹⁰² Many jurisdictions responded to this ambiguity by creating their own state child custody statutes with a combination of some or all of UMDA's requirements and adding guiding principles and factors to take into consideration when determining the best interest of the child.¹⁰³ A few states go further and list factors which should not be considered in the best interest analysis,¹⁰⁴ while some merely provide merely general guidance and allow courts more discretion to make such determinations.¹⁰⁵ Regardless of the extensive variations in details, best interest of the child remains the prevailing standard used by courts to determine custody.¹⁰⁶

B. THE BEST INTEREST OF THE CHILD: THE GOOD AND THE BAD

The best interest of the child standard has no specific definition, but generally "refers to the deliberation that courts undertake when deciding what types of services, actions, and orders will best serve a child as well as who is best suited to take care of a child."¹⁰⁷ Such determinations are "made by considering a number of factors related to the child's

101. UNIF. MARRIAGE & DIVORCE ACT § 402 (1970).

102. UNIF. MARRIAGE & DIVORCE ACT § 402 (1970).

103. *Determining the Best Interest of the Child: State Statutes*, CHILD WELFARE INFO. GATEWAY, https://www.childwelfare.gov/pubPDFs/best_interest.pdf (last updated Nov. 2012).

104. CONN. GEN. STAT. ANN. § 45a-719 (2016) ("The determination of the best interest of the child shall not be based on a consideration of the socio-economic status of the birth parent or the caretaker."); DEL. CODE ANN. tit. 13, § 722 (2016) ("The court shall not presume that a parent, because of his or her sex, is better qualified than the other parent to act as a joint or sole legal custodian for a child or as the child's primary residential parent, nor shall it consider conduct of a proposed sole or joint custodian or primary residential parent that does not affect his or her relationship with the child."); IDAHO CODE § 16-1601 (2016) ("Nothing in this chapter shall be construed to allow discrimination on the basis of disability.").

105. *Determining the Best Interest of the Child*, *supra* note 103, at 4 (Alabama, Alaska, Arizona, Arkansas, California, Colorado, Georgia, Idaho, Indiana, Iowa, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Utah, Washington, West Virginia, and Wyoming).

106. June Carbone, *Legal Applications of the "Best Interest of the Child" Standard: Judicial Rationalization or a Measure of Institutional Competence?*, 134 PEDIATRICS, supp. 2, Oct. 2014, available at http://pediatrics.aappublications.org/content/pediatrics/134/Supplement_2/S111.full.pdf.

107. *Determining the Best Interests of the Child*, *supra* note 103, at 2.

circumstances, and the parent or caregiver's circumstances and capacity to parent, with the child's ultimate safety and well-being as the paramount concern."¹⁰⁸

Presumably, no reasonable person would argue that considering the best interest of the child is not of utmost importance in adjudicating custody. While the best interest of the child standard may be ideal and simplistic, the lack of a precise definition and criteria of how to keep a child's best interest protected by a court of law is a double-edged sword. The standard strives to preserve children's rights by giving them a voice as to the custody matter and keeping children's welfare central to the determination.¹⁰⁹ An important benefit of the best interest of the child standard is its focus on "children's developmental and psychological needs, rather than on parental demands, societal stereotypes or legal tradition."¹¹⁰ This departure from explicit presumptions and blanket rules leaves courts with room to look at the unique circumstances of a case and child at hand, and grants judges wide discretion to make decisions based on specifically tailored, case-by-case analyses, rather than making generalizations about what is the best for all children or the average child.¹¹¹ The individualized determination makes the best interest of the child standard adaptable to change and "able to accommodate new knowledge and understanding about children's needs and to respond to changing legal and social trends."¹¹²

Still, the best interest of the child standard is far from perfect. Skeptics repudiate it as the solution to resolving child custody matters for many reasons, all which are, generally, related to the standard's inherently discretionary quality. The standard lacks objectivity and scientifically valid rules to guide courts in making best interest analyses. Further, there is a lack of uniformity as to the various factors to consider, leaving open questions of how to define and weigh the different factors and "how to account for children's changing developmental needs over time."¹¹³ At best, the standard is "an aspirational statement."¹¹⁴

Deciding what is best for a child is difficult, if not impossible - ask any parent. Reasonable minds differ, as even legal, judicial, and mental health communities disagree about what the child's best interests are for a custody battle. Despite states' efforts to give courts more guidance by attaching some concrete and objective terms, and elaborating long lists of factors to

108. *Id.*

109. Andrew Shepard, *Best Interests of the Child*, CHILD CUSTODY PROJECT, <http://childcustodyproject.org/essays/best-interests-of-the-child/> (last visited Feb. 20, 2016).

110. Kelly, *supra* note 99, at 128.

111. *Id.*

112. Warshak, *supra* note 99, at 100.

113. Kelly, *supra* note 99, at 129.

114. Shepard, *supra* note 109 ("Essentially, the best interests test is at best an aspirational statement; it is what society hopes the outcome of a child custody dispute will be rather than a proscription for a particular type of custody arrangement in a particular family.").

be considered in their statutes, not all do. Regardless, albeit to varying degrees, the best interest of the child standard requires a judge to make a subjective decision based on what he or she thinks is best for the child in the case at hand.¹¹⁵ Depending on the judge's values and beliefs as to what matters to the child's welfare will inevitably guide his decision.¹¹⁶ What one judge believes to be the best result for a child in certain circumstances may be completely opposed by another judge. The difficulty of determining what truly is the best interest of a child coupled with the wide judicial discretion the standard calls for, creates an overwhelming amount of unpredictability for parents.

The federal government's continued rejection of marijuana's medical value not only permits, but also unfortunately encourages discrimination against those who use marijuana for legitimate medical reasons like Charlotte Figi, the six-year-old experienced up to 300 grand mal seizures every week until her parents decided to treat her with cannabis oil, a form of marijuana.¹¹⁷ The disparity between states with progressive marijuana laws and the decades-old federal prohibition has caused confusion in many areas of the law, including child custody. Since federal law remains supreme and trumps state laws, a judge in a child custody case may use the parent's use of marijuana or the parent's providing it for their child as evidence of the parent's inability to properly care for the child, even if doing so in full compliance with the state's permissive medical marijuana laws. Consequently, if a family like Charlotte's family faced a child custody battle, a judge could, potentially, use his personal negative opinions about marijuana to discriminate against them, determining it to be in the best interest of the child, even though Colorado has permitted marijuana use for people suffering exactly as Charlotte did before using medical marijuana. Thus, there is a need for legislative change to guide judges not consider medical marijuana, alone, as determinative of parental fitness so parents like Charlotte's parents are not at risk of losing child custody rights for choosing to medicate with marijuana.

PART III: THE INTERSECTION OF MEDICAL MARIJUANA AND CHILD CUSTODY AND THE NEED FOR ANTICUSTODY DISCRIMINATION LAWS

In order to preserve the state sanctioned right to medicate with marijuana, all current and future medical marijuana statutes need specific legislation protecting parents from discrimination based on their status as a

115. Katharine T. Bartlett, *Child Custody in the 21st Century: How the American Law Institute Proposes to Achieve Predictability and Still Protect the Individual Child's Best Interests*, 35 WILLAMETTE L. REV. 467, 471 (1999).

116. *Id.*

117. Young, *supra* note 85.

medical marijuana patient in child custody cases. As a result of marijuana's growing acceptance as a valuable medicinal resource and states' subsequent legalization of medical marijuana, family courts are faced with complicated cases regarding the interplay between medical marijuana and child custody. A major concern is how a parent's use of medical marijuana will be considered, if at all, in the final determination of what is in the best interest of the child. This is a rather unexplored territory as marijuana was first legalized for its medical use by California only about twenty years ago. Out of the twenty-four states plus the District of Columbia with legalized medical marijuana after California, eleven have done so just within the last six years.

Not all courts refuse to use a parent's medical marijuana use per se to form the basis for removing a parent's custodial rights.¹¹⁸ The purchase, cultivation, and possession of marijuana are still prohibited under federal law, meaning, "a court could quite easily conclude that allowing such a parent extensive supervision of a minor child is not in the child's best interest."¹¹⁹ As a result, children have been removed from safe, loving homes because their parent is a qualified medical patient and user, and solely based on the false presumption that the presence of marijuana poses a danger.¹²⁰ Since there is no clear and consistent answer to the question of how the use of medical marijuana will affect a child custody case, parents are forced to sacrifice their state authorized right to legally medicate with marijuana, in order to prevent custody issues or retain custody of their children.

Medical marijuana statutes were enacted to allow citizens the right to use marijuana for various medical conditions while protecting qualified patients and their recommending doctors from criminal prosecution.¹²¹ In order to preserve the state sanctioned right to medicate with marijuana, all current and future medical marijuana statutes need specific legislation protecting parents from discrimination based on their status as a medical marijuana patient in child custody cases. Currently, only ten out of the twenty-four states plus the District of Columbia have done exactly this. While varying in small details, generally, those ten states include language in their medical marijuana statutes intended to prevent discrimination by stating, for the most part, "no person may not be denied custody of or visitation of parenting time with a minor" and establishes "there is no

118. Chemerinsky, *supra* note 9 at 99.

119. *Id.* at 100.

120. Gene Johnson, *Medical Pot Can Cost Parents in Custody Disputes*, ASSOCIATED PRESS (June 20, 2010), www.safeaccessnow.org/asanews3738 ("Lauren Payne, legal services coordinator with a California marijuana law reform group called Americans for Safe Access, said that since mid-2006 her organization has received calls about 61 such cases.").

121. *See* statutes cited, *supra* note 2.

presumption of neglect or child endangerment” for the conduct permitted in the state’s medical marijuana statute, “unless the person’s behavior creates an unreasonable danger to the safety of the minor as established by clear and convincing evidence.”¹²² While these anticustody discrimination provisions are not complete protections for medical marijuana patient-parents, they attempt to alleviate the problem of uncertainty caused by judges’ broad discretion in custody cases and marijuana’s conflicting disposition under permissive state law and prohibitive federal law. They provide courts with statutory guidance to look for other probative circumstances in a particular case, rather than basing a ruling on the parent’s status as a medical marijuana patient. This encourages the courts to further harness the spirit of the democratically enacted medical marijuana statutes, which is to give people the right to use medical marijuana to treat their pain and suffering without facing discrimination for doing so.

Such anticustody discrimination provisions are important to include in all medical marijuana statutes because the result of a child custody case involving medical marijuana largely depends on whether the people involved, Child Protective Services (“CPS”), judges, and attorneys have biases against parents who use marijuana, even for medical purposes.¹²³ There are generally two contexts in which a parent’s medical marijuana use may affect their custodial rights.¹²⁴

First, CPS gets involved if they receive a report from someone, such as a family member, teacher, or neighbor, about the safety of a child.¹²⁵ A social worker may be sent to investigate the home of that child, and the discovery of the use or possession of marijuana by a parent could trigger the agency, in the worst-case scenario, to seek termination of all parental rights and take away the child, putting them in custody of relatives or making them dependents of the court.¹²⁶ In that sense, CPS has incredible amount of power over parents and as marijuana is still a Schedule I drug under federal law, marijuana use or possession is enough to justify taking such actions. In order to reclaim custody of their child, the parent may

122. ARIZ. REV. STAT. § 36-2813 (standard example of an anticustody discrimination law); *see supra* note 7 for the other anticustody discrimination laws.

123. *Child Custody*, AMERICANS FOR SAFE ACCESS: ADVANCING LEGAL MEDICAL MARIJUANA THERAPEUTICS AND RESEARCH, http://www.safeaccessnow.org/ca_child_custody (last accessed Mar. 3, 2016); Sara Arnold, *Marijuana & Child Custody*, FAMILY LAW & CANNABIS ALLIANCE, fcalliance.org/writing/marijuana-child-custody/ (last accessed Mar. 4, 2016) (explaining how medicinal or recreational cannabis use is considered a huge problem by both CPS and in family court for parents, even in states with medical and/or decriminalization laws).

124. Michele LoBello, *Cannabis or Custody*, ATTORNEY AT LAW MAGAZINE, vol. 3, no.3, at 7, <http://digital.ipcprints.com/publication/index.php?i=-235666&m=22404&l=1&p=7&pre=> (last accessed Mar. 3, 2016).

125. *Id.*

126. *Id.*

have to undergo drug therapy programs and ongoing drug tests to show the family court that the child is no longer in any kind of risk of marijuana exposure.¹²⁷

The second context is in a custody battle where one parent could use the other parent's status as a medical marijuana patient to establish that parent as unfit in an attempt to limit his or her contact with the child.¹²⁸ Once the case reaches family court, the fate of the child rests in the hands of the presiding judge who has incredible discretion to make custody determinations. A judge can disregard a parent's status as a medical marijuana patient as a nonfactor, but not all do. As a result, parents are often unable to predict how a judge will rule. The judge's personal philosophies about marijuana use, even for purely medical purposes, can affect each ruling. A conservative judge may consider marijuana as the devil's lettuce and agree with marijuana's federal Schedule I status as to lacking any true medical benefit. In that case, the fact that a parent is a qualified patient with a valid prescription may not matter to the judge. Another judge may take a more relaxed stance and supportive of the reasonable use of medical marijuana under safe conditions. Depending on the judge, even the most capable parent using marijuana strictly for legitimate medical conditions may be considered an unfit parent, limiting his or her parental rights.

In either context, a parent remains uncertain as to the result of a custody case and about the future of their child. Anticustody discrimination provisions work to the benefit of everyone involved because it provides guidance on how a court should consider a parent's use of medical marijuana, specifically, that a court will not discriminate against those parents. The California Court of Appeal has approved this sentiment in *In re Alexis E.*, where the court held "use of medical marijuana, without more, cannot support a jurisdiction finding that such use brings the minor within the jurisdiction of the dependency court."¹²⁹ For this court there needed to exist other factors could add to the conclusion that it was in the best interest of the child to remove him or her from the custody of their parent. However, in this case, the father's marijuana use in the presence of his children created negative second-hand smoke and the resulting change in demeanor while using marijuana was sufficient to sustain the juvenile court's determination that the father's use of marijuana presented a danger to the children, despite using marijuana in accordance with California's Compassionate Use Act.¹³⁰ Rather than deciding on the marijuana use per

127. *Id.*

128. LoBello, *supra* note 124.

129. *In re Alexis E.*, 171 Cal. App. 4th 438, 453 (2009).

130. *Id.* at 452-453.

se, the court justified the conclusion with the marijuana's negative secondary effects.

Another "victory for parents who use medical marijuana" occurred in a more recent case by the California appellate court. In *In re Drake M.*, the court distinguished for the first time between substance abuse and substance use in juvenile dependency law.¹³¹ Overturning the trial court's judgment for abuse of discretion, the court held that medical marijuana use alone, without any evidence that "such usage has caused serious physical harm or illness or places a child at substantial risk of incurring serious physical harm," does not constitute child abuse or put children at risk.¹³² Thus, the Los Angeles County Department of Children and Family Service's argument that the father was regularly under the influence while caring for his child was not "proof in and of itself that Drake M. was suffering from neglect or harm."¹³³ The California Court of Appeal followed the intent of the anticustody discrimination statutes and rejected discrimination in a custody case on the sole basis of a parent using medical marijuana.

These two cases exemplify the effects of including antidiscrimination provisions in all medical marijuana statutes. Through these antidecimation provisions, legislators can further the goals of the medical marijuana statutes by ensuring those who are qualified to use marijuana to treat their pain and suffering are protected from discrimination in child custody situations. Having straight such forward language within the medical marijuana statutes will prohibit judges from using their personal stance about marijuana to overshadow any other considerations in a particular custody case so that they cannot rule per se based on a parent's status as a medical marijuana patient or their administration of medical marijuana to their sick child.

CONCLUSION

All current and future medical marijuana states must protect parents who use their state sanctioned right to treat their medical conditions with marijuana from discrimination in child custody cases. Although marijuana's acceptance among the American public has grown significantly, its status as a Schedule I, federally prohibited drug conflicts with states' permissive statutes legalizing its medical use. This creates a complicated problem when use and possession of marijuana, for medical purposes, reaches family courts in the form of custody cases. The prevailing standard, the best interest of the child, grants judges wide discretion in determining child custody cases. Without clear, legislative

131. *In re Drake M.*, 211 Cal. App. 4th 754, 764–66 (2012).

132. *In re Drake M.*, 211 Cal. App. 4th at 769.

133. *Id.*

language in all medical marijuana statutes providing guidance on how a court should consider medical marijuana use, the judges are free to use their biases against parents using marijuana for legitimate medical needs. They have the authority to consider a parent's status as a medical marijuana patient as indicative of his parental fitness.

This proposal for legislative reform is not to apply a blanket protection for medical marijuana patients. Having a valid prescription from a physical does not allow a parent can use marijuana and be guaranteed custody of his or her kids. Even if parent-patient is using medical marijuana in full compliance of the state statute, there is still chance that legal activity may be harmful to a child. Alcohol is legal to consume, but if a parent misuses it, a reasonable person would agree that it would impair a person's ability to adequately care for a child. Medical marijuana patients or providers with children need to be careful and aware of the potential harm children can face in light of their decision to use medical marijuana.

The inclusion of anticustody discrimination language works to maintain the spirit of medical marijuana statutes, allowing an individual the right to choose marijuana to alleviate their pain and suffering, while preserving the judge's discretion to determine child custody cases on an individualized, case-by-case basis, making decisions based on what is best for the child in the particular case at hand. A child's safety and well-being is a top priority, but so is the right for a patient to choose a state-sanctioned, legal medical treatment for their pain and suffering. The fourteen states and the District of Columbia that are silent about custody in their medical marijuana statutes must afford their citizens the same protection currently offered by ten states with such anticustody discrimination provisions. A parent should not be persecuted for choosing to use marijuana to treat a serious medical issue, in full compliance of state law and without putting their children at any risk. No parent should feel insecure about whether his or her children will be taken away from their home without the existence of other issues indicating neglect or abuse. Patient-parents should not have to live in fear of the unknown. If a parent's conduct does not create an unreasonable danger to their child, their use of medical marijuana should not be considered by the court to support its adverse custody determination. Being a qualified medical marijuana patient and using marijuana to treat an individual's pain and suffering, alone, is not indicative of a person's ability or inability to love and care for a child. Until the federal government relaxes its prohibition on marijuana by recognizing its great medicinal value and removing it from Schedule I, it is imperative state legislators memorialize this sentiment by enacting antidiscrimination provisions into states' medical marijuana statutory schemes.