

Indiana Health Law Review

Volume XXII

2025

Number 1

NOTES

INDIANA’S PUNITIVE RESPONSES TO PRENATAL MARIJUANA USE: A RECOMMENDATION FOR THE INDIANA LEGISLATURE

SARAH BROWN*

I. INTRODUCTION

Forty-three years ago, President Ronald Reagan stated marijuana was “probably the most dangerous drug in the United States.”¹ Reagan’s presidency was, in part, defined by his expansion of President Richard Nixon’s proclaimed “War on Drugs,” an era of United States’ law and policy which increased punishment for use and possession of many illegal drugs, including marijuana.² Although the “War on Drugs” has gradually relaxed and led to the full or partial legalization of marijuana in thirty-eight states,³ the effects of the “War” are still felt throughout the country. Specifically, Indiana retains “War on Drugs” era policies through its child abuse statutes which penalizes maternal marijuana use.

Indiana child abuse statutes govern the treatment of children born marijuana positive. Under Indiana law, a child is considered a “child in need of services” (CHINS)⁴ if any amount, including a trace amount, of marijuana is found in their system and the child needs care, treatment, or rehabilitation that is unlikely without court intervention.⁵ Furthermore, hospital drug testing policies and the Indiana Department of Child Services (DCS) supports Indiana’s legal framework by discovering, investigating, and civilly pursuing cases of

* JD Candidate 2025, Indiana University Robert H. McKinney School of Law. The author thanks Professor Frank Sullivan Jr., Katie Kelsey, and Professor Michael Pitts for their support of this Note. The author also thanks the editors of the *Indiana Health Law Review* for their support in preparing this note for publication.

1. Kyle Jaeger, *How Marijuana Ruined Ronald Reagan’s Valentine’s Day*, MARIJUANA MOMENT (Feb. 14, 2019), <https://www.marijuanamoment.net/how-marijuana-ruined-ronald-reagans-valentines-day/> [<https://perma.cc/6WQ8-SCZN>].

2. *War on Drugs*, HISTORY.COM (May 31, 2017), <https://www.history.com/topics/crime/the-war-on-drugs> [<https://perma.cc/98GM-W29Y>].

3. *State Medical Cannabis Laws*, NAT’L CONF. OF STATE LEGISLATURES (June 22, 2023), <https://www.ncsl.org/health/state-medical-cannabis-laws> [<https://perma.cc/TGK6-MJ7D>].

4. CHINS is a term which includes a wide array of circumstances of child abuse and neglect. See IND. CODE § 31-34-1-1 (2024) (circumstances under which a child is a child in need of services).

5. IND. CODE § 31-34-1-10 (2024).

marijuana-positive infants.⁶ Although the Indiana Court of Appeals held in 2015 that in-utero marijuana exposure standing alone is not a sufficient basis to support a child abuse or neglect petition,⁷ DCS continues involvement in such families.⁸ While these laws and policies are meant to protect infants from abuse through the agency's involvement, medical racism and a lack of trust between a health care provider and patients causes numerous harms to families.

Prenatal marijuana use is a common occurrence in the United States. Between 2016-2017, 7% of pregnant individuals self-reported marijuana use during pregnancy.⁹ However, self-reported data can be inaccurate¹⁰ and use among certain populations are estimated to be higher. For example, 14–28% of low-income, urban women are estimated to use marijuana during pregnancy.¹¹ Research has not conclusively connected in-utero marijuana exposure to any adverse infant health outcomes.¹² Although some research has suggested a connection with low birth weight, these connections have not been definitively proven.¹³ The harm to families created by Indiana's response to prenatal marijuana use outweighs the potential harms to the infant exposed. This note will discuss the effects of prenatal marijuana use on mother and infant and the relevant policies and laws which currently govern the Indiana's response to marijuana-exposed infants. Additionally, this note will address the harms resulting from these policies and laws, potentials for reform within Indiana hospitals and DCS, and end with a recommendation that Indiana Legislature exclude marijuana from the state's definition of child abuse.

6. Most states do not have criminal penalties for maternal drug use. In states with criminal statutes, the focus is on opioid use. See Emma Coleman, *Many States Prosecute Pregnant Women for Drug Use. New Research Says That's a Bad Idea*, VAND. UNIV. CTR. FOR CHILD HEALTH POL'Y (Dec. 5, 2019), <https://www.vumc.org/childhealthpolicy/news-events/many-states-prosecute-pregnant-women-drug-use-new-research-says-thats-bad-idea> [https://perma.cc/9G79-RMGX].

7. *A.M. v. Ind. Dep't of Child Servs. (In re S.M.)*, 45 N.E.3d 1252, 1256 (Ind. Ct. App. 2015).

8. See generally *A.M. v. Ind. Dep't of Child Servs. (In re Ad.M.)*, 103 N.E.3d 709, 711-712 (Ind. Ct. App. 2018).

9. Nora D. Volkow et al., *Self-reported Medical and Nonmedical Cannabis Use Among Pregnant Women in the United States*, 322 JAMA 167, 168 (2019).

10. NAT'L ACADS. SCIS., ENG'G, AND MED., *THE HEALTH EFFECTS OF CANNABIS AND CANNABINOIDS: THE CURRENT STATE OF EVIDENCE AND RECOMMENDATIONS FOR RESEARCH* 245 (Robert Pool ed. 2017).

11. Samarth Shukla & Harshit Doshi, *Marijuana and Maternal, Perinatal, and Neonatal Outcomes*, EUR. PMC (2023), https://europepmc.org/article/NBK/nbk570616#_NBK570616_dtls [https://perma.cc/8Z3B-2V9D].

12. COMM. OBSTETRIC PRAC., *Committee Opinion No. 722: Marijuana Use During Pregnancy and Lactation*, 130 AM. COLL. OBSTETRICIANS & GYNECOLOGISTS 205, 206 (2017).

13. Hanan El Marroun et al., *Intrauterine Cannabis Exposure Affects Fetal Growth Trajectories: The Generation R Study*, 48 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 1173, 1181 (2009).

II. BACKGROUND

A. *What Is Marijuana?*

Marijuana is an alternative name for cannabis, a plant within the hemp family.¹⁴ Marijuana is hemp that contains primarily two chemicals: delta-9-tetrahydrocannabinol and cannabidiol.¹⁵ Delta-9-tetrahydrocannabinol (THC) is a psychoactive chemical which causes the user to feel an euphoric high.¹⁶ THC crosses the placenta and can reach high concentrations in infant's systems due to repeated in-utero exposure.¹⁷ THC-containing products can be smoked, ingested, vaporized, or topically applied depending on the type of product used,¹⁸ and the potency of THC substance differs depending on the type of product.¹⁹

Conversely, cannabidiol (CBD) does not deliver the same psychoactive effects as THC, therefore, users do not feel a "high" after consumption.²⁰ CBD produces the opposite effect of THC as it functions to decrease the psychological reactions of THC when consumed together.²¹ Isolated CBD has been shown to reduce anxiety, inflammation, and produce sedative-like effects.²² There are three common types of THC-related products: marijuana, isolated cannabidiol (CBD), and delta-8 tetrahydrocannabinol (Delta-8).

Marijuana is currently illegal in the state of Indiana and it is classified as a Schedule 1 narcotic.²³ To be classified as Schedule 1, the Indiana legislature must determine that the substance has a high potential for abuse, has no accepted medical use in treatment, and there is a lack of accepted safety for use under medical supervision.²⁴ Marijuana was legal in the State until 1913 when its use was restricted and only allowed with a doctor's prescription.²⁵ Marijuana use for medical reasons became illegal after the passage of the Controlled Substances

14. See LESLIE L. IVERSEN, *THE SCIENCE OF MARIJUANA* 5 (1st ed. 2000).

15. Zerrin Atakan, *Cannabis, a Complex Plant: Different Compounds and Different Effects on Individuals*, 2 THERAPEUTIC ADVANCES PSYCHOPHARMACOLOGY 241, 241 (2012).

16. Shukla & Doshi, *supra* note 11.

17. *Id.*

18. CENTER FOR DISEASE CONTROL AND PREVENTION, *What We Know About Marijuana*, (Sept. 9, 2021), <https://www.cdc.gov/marijuana/what-we-know.html> [<https://perma.cc/3REV-X8WX>].

19. Stacy Steigerwald et al., *The Form and Content of Cannabis Products in the United States*, 33 J. GEN. INTERNAL MED. 1426, 1428 (2018).

20. *CBD: What You Need to Know*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Aug. 8, 2022), [https://www.cdc.gov/marijuana/featured-topics/CBD.html#:~:text=Cannabidiol%20\(CBD\)%20is%20a%20compound,not%20cause%20a%20](https://www.cdc.gov/marijuana/featured-topics/CBD.html#:~:text=Cannabidiol%20(CBD)%20is%20a%20compound,not%20cause%20a%20) [<https://perma.cc/VDT4-TL2N>].

21. Atakan, *supra* note 15, at 245.

22. *Id.*

23. IND. CODE § 35-48-2-4(d)(22) (2024).

24. IND. CODE § 35-48-2-3 (1976).

25. *Indiana Marijuana Laws 2024*, INDIANA CANNABIS INFORMATION <https://indiana.cannabis.org/laws#> [<https://perma.cc/3JHU-48H4>] (last visited Jan. 31, 2024).

Act of 1970 which federally classified marijuana as a Schedule 1 Narcotic.²⁶ In 2024, all bills in the Indiana Legislature regarding the full or partial legalization of marijuana have failed.²⁷

The second product available in Indiana is isolated CBD. Although isolated CBD is not meant to contain noticeable levels of THC, CBD products are susceptible to manufacturing deficiencies and mislabeling, resulting in an estimated 21% of CBD products containing levels of THC which can appear on a drug test.²⁸ In the Indiana 2024 legislative session, bills aiming to create regulatory testing and packaging requirements for low THC hemp products are pending in the Senate.²⁹ CBD products are widely available throughout Indiana in a variety of products such as oils, edibles, and topical lotions.³⁰ Furthermore, CBD became legal in Indiana following the passage by Congress of the 2018 Farm Bill.³¹ The 2018 Farm Bill federally legalized products containing less than 0.3% of THC³² and Indiana adopted the federal law into the Indiana Code within a year.³³

Lastly, delta-8 tetrahydrocannabinol (Delta-8) is another product created from hemp. Delta-8 is a psychoactive substance derived from the cannabis sativa plant, a type of marijuana,³⁴ which will result in a positive THC drug test if used.³⁵ Delta-8 is commonly found in smokable oils and edibles which can be purchased at a variety of stores throughout Indiana. Similarly to CBD, Delta-8 became legal in Indiana after the passage of the 2018 Farm Bill.³⁶ However, the legality of Delta-8 is currently being assessed. Delta-8's legal status in Indiana

26. 21 U.S.C. § 812 (1970).

27. S.B. 107, 123rd Gen. Assemb., Second Reg. Sess. (Ind. 2024) (establishing regulations for the production and sale of cannabis); H.B. 1146, 123rd Gen. Assemb., Second Reg. Sess. (Ind. 2024) (legalizing medical marijuana); H.B. 1282, 123rd Gen. Assemb., Second Reg. Sess. (Ind. 2024); H.B. 1350, 123rd Gen. Assemb., Second Reg. Sess. (Ind. 2024); H.B. 1410, 123rd Gen. Assemb., Second Reg. Sess. (Ind. 2024); H.B. 1349, 123rd Gen. Assemb., Second Reg. Sess. (Ind. 2024) (decriminalizing personal use marijuana possession).

28. Staff Sgt. Tony Harp, *CBD Can Trigger Positive Drug Test*, JOINT BASE SAN ANTONIO (Jan. 16, 2020), <https://www.jbsa.mil/News/News/Article/2057582/cbd-can-trigger-positive-drug-test/#:~:text=The%20simple%20answer%3A%20No.,Military%20Drug%20Demand%20Reduction%20Program> [https://perma.cc/JNP9-HM26].

29. S.B. 59, 123rd Gen. Assemb., Second Reg. Sess. (Ind. 2024) (creating requirements for testing and packaging of hemp products); S.B. 175, 123rd Gen. Assemb., Second Reg. Sess. (Ind. 2024) (creating packing regulations for low THC hemp products).

30. *CBD: What You Need to Know*, *supra* note 20.

31. Agricultural Improvement Act of 2018, Pub. L. No. 115-334 §10113, 132 Stat. 4490, 4908 (2018).

32. *Id.*

33. IND. CODE § 15-15-13-7 (2019).

34. *5 Things to Know about Delta-8 Tetrahydrocannabinol – Delta-8 THC*, FDA (May 4, 2022), <https://www.fda.gov/consumers/consumer-updates/5-things-know-about-delta-8-tetrahydrocannabinol-delta-8-thc> [https://perma.cc/9ZQD-9ECQ].

35. Sian Ferguson, *Does Delta-8 Show Up on a Drug Test?*, HEALTHLINE (Mar. 15, 2023) <https://www.healthline.com/health/does-delta-8-show-up-on-a-drug-test> [https://perma.cc/43TZ-ZT7W].

36. IND. CODE § 15-15-13-7 (2019).

may change due to Indiana Attorney General Todd Rokita's advisory opinion stating that the substance is illegal in the State due to the prohibition on marijuana.³⁷

B. Pregnancy and THC Use

1. Why Do Women Use Marijuana During Pregnancy?

Skeptics of marijuana question why a woman would use the substance while pregnant. In fact, stigma and guilt caused by marijuana use is a major reason many women choose to stop use during pregnancy.³⁸ Nevertheless, many choose to continue to use it for a variety of motivations. A 2021 study found three main reasons mothers use marijuana during pregnancy: recreational enjoyment, symptom and pain management, or emotional coping.³⁹ The majority of participants identified more than one category for their use.⁴⁰ However, the most common reason was for symptom and pain management during pregnancy.⁴¹ Many used marijuana outside of the advice of a medical professional and believed marijuana eased their nausea and vomiting more effectively than prescribed medications.⁴² Only one participant identified their sole reason for use as recreational enjoyment.⁴³

The stigma surrounding prenatal marijuana use also affects the mother's consumption. Although the exact risks of marijuana use are largely unknown to both medical providers and expecting mothers, a study found a universal agreement from all participants that there was a high risk of being reported to child protective services if the use was revealed to a healthcare provider.⁴⁴ Furthermore, most women attempted to decrease their use or quit use altogether during the third trimester,⁴⁵ likely to avoid detection.

Cultural effects from legalized areas of the United States may also be influencing overall maternal marijuana use. A 2020 study found that women

37. Tetrahydrocannabinol Variants and Other Designer Cannabinoid Products, IND. OP. ATT'Y GEN. 2023-1, 1–2 (2023); *see also* 3C, LLC v. Rokita, No. 23-cv-01115-JRS-MKK, 2024 WL 1348221 (S.D. Ind. Mar. 29, 2024); Marella Porter, *Decisions on Delta 8 Ban in Indiana Expected Following Lawsuit*, WKRC NEWS (Jan. 19, 2024) <https://local12.com/news/local/decisions-on-delta-8-ban-in-indiana-expected-any-day-following-lawsuit#> [<https://perma.cc/35GF-WUHY>].

38. Meredith Vanstone et al., *Reasons for Cannabis Use During Pregnancy and Lactation: a Qualitative Study*, 193 CAN. MED. ASS'N J. 1906, 1910 (2021).

39. *Id.* at 1906.

40. *Id.*

41. *Id.* at 1910.

42. *Id.*; *see also* Judy C. Chang et al., *Beliefs and Attitudes Regarding Prenatal Marijuana Use: Perspectives of Pregnant Women Who Report Use*, 196 DRUG & ALCOHOL DEPENDENCE 14, 16 (2019).

43. Vanstone et al., *supra* note 39, at 1906.

44. Chang et al., *supra* note 43.

45. *Id.*

residing in legal recreational marijuana states were 2.21 times more likely to use marijuana during pregnancy compared to those in illegal states.⁴⁶ Furthermore, a 2018 study found that 70% of Colorado marijuana dispensaries recommended cannabis to pregnant women to treat nausea during the first trimester.⁴⁷ The uncertainty surrounding the effects of maternal marijuana use and the perceived benefits of use from cannabis industry actors has culminated in an online community of mothers that recommend use during pregnancy. Due to the illegality of marijuana and the fear of child protective services involvement, many women turn to online chat rooms for information rather than seeking out the advice of healthcare professionals.⁴⁸ These online chat rooms focus more on personal testimonies and experiences and questions about hospital testing policies is the topic with the highest frequency of posts.⁴⁹ The most common post in these chat rooms are state-specific questions looking for information on how to avoid detection from child services in the mother's home state.⁵⁰ The stigma of prenatal marijuana use and the culture of fear surrounding child services involvement encourages mothers who are using to seek out non-medical advice online which could have detrimental effects on prenatal care.⁵¹

2. Marijuana's Effects on Infants

Marijuana use among pregnant women is rising in the United States.⁵² Healthcare providers are advised to never encourage the use of marijuana during pregnancy.⁵³ However, there is currently insufficient data to support any adverse effects of in-utero marijuana exposure in infants.⁵⁴ Specifically, research has found no connection between maternal marijuana use and the adverse pregnancy outcomes of small for gestational age; spontaneous preterm birth; and pregnancy hypertensive disorders.⁵⁵ Furthermore, neonatal intensive care unit admission rates are not statistically different between marijuana-positive infants and non-positive infants.⁵⁶ Overall, current research does not connect maternal

46. Kara R. Skelton et al., *Recreational Cannabis Legalization in the US and Maternal Use During the Preconception, Prenatal, and Postpartum Periods*, 17 INT'L J. ENV'T RSCH. & PUB. HEALTH 909, 912 (2020).

47. Betsy Dickson et al., *Recommendations From Cannabis Dispensaries About First-Trimester Cannabis Use*, 131 OBSTETRICS & GYNECOLOGY 1031, 1032 (2018).

48. Cynthia N Lebron, et al., "Ganja Mamas": *Online Discussions about Cannabis Use in Pregnancy*, 241 DRUG & ALCOHOL DEPENDENCE 109689, 109691 (2022).

49. *Id.* at 109697.

50. *Id.* at 109692.

51. *Id.* at 109697.

52. Kelly C. Young-Wolff et al., *Rates of Prenatal Cannabis Use Among Pregnant Women Before and During the COVID-19 Pandemic*, 326 JAMA 1745, 1745 (2021).

53. COMM. OBSTETRIC PRAC., *supra* note 12, at 205.

54. *Id.* at 206.

55. Torri Metz et al., *Maternal Marijuana Use, Adverse Pregnancy Outcomes, and Neonatal Morbidity*, 217 AM. J. OBSTETRICS & GYNECOLOGY 478, 484 (2017).

56. *Id.* at 479.

marijuana use to risks of physical harm or deformities in infants exposed in-utero.⁵⁷

However, some studies suggest a risk of physical harm to infants' post-birth from in-utero marijuana exposure, however, these findings are not certain. Some studies have found a connection between maternal marijuana use and low birth weight, however, inconsistencies in the studies call their findings into question.⁵⁸ Many of the studies rely on birth weight alone which is not reliable indicator for fetal growth, utilize small sample sizes, and do not account for the potency of the marijuana used by the pregnant person.⁵⁹ Furthermore, it is difficult to discern the exact effects of marijuana on infants because marijuana-positive infants are at a higher risk of also being exposed to tobacco, alcohol, or other illicit drugs.⁶⁰

The College of Obstetricians and Gynecologists has recommended individuals discontinue marijuana use during pregnancy, however, their reaffirmed 2021 opinion states there is no current association between marijuana use and increased risk of stillbirth, low birth weight, and pre-term birth.⁶¹ Furthermore, the College of Obstetricians and Gynecologists stated that many studies on maternal marijuana use are limited by the use of animals in the research and the effect of tobacco use on the affected infants.⁶² Overall, the current research does not connect marijuana use alone to adverse infant health outcomes and the current opinion is that the risk of harm is minimal.⁶³

C. Indiana Law

1. Indiana Child Welfare Statute § 31-34-1-10

Indiana child welfare statutes, referred to as Child in Need of Services (CHINS) law, is the primary source of law that governs the penalties for marijuana-positive infants. Indiana CHINS statutes require three conditions to support a child welfare petition: (1) the child is under eighteen years old; (2) the abuse or neglect meets one of the eleven statutory definitions of abuse or neglect; and (3) the child needs intervention from the court.⁶⁴ Indiana DCS must prove the three conditions by a preponderance of the evidence to adjudicate the

57. COMM. OBSTETRIC PRAC., *supra* note 12, at 206.

58. Marroun et al., *supra* note 13, at 1181.

59. *Id.*

60. See COMM. OBSTETRIC PRAC., *supra* note 12; Sheryl A. Ryan et al., *Marijuana Use During Pregnancy and Breastfeeding: Implications for Neonatal and Childhood Outcomes*, 142 AM. ACAD. PEDIATRICS 1889 (2018); see also Shukla & Doshi, *supra* note 11.

61. COMM. OBSTETRIC PRAC., *supra* note 12, at 206.

62. *Id.* at 207.

63. *Id.*

64. M.Y. v. State Dep't of Child Servs. (*In re K.Y.*), 145 N.E.3d 854, 860 (Ind. Ct. App. 2020); see also A.R. v. Ind. Dep't of Child Servs. (*In re A.R.*), 121 N.E.3d 598, 603 (Ind. Ct. App. 2019).

child a child in need of services.⁶⁵

Among the statutory definitions of abuse or neglect is Indiana law section 31-34-1-10, which states:

- (1) The child is born with:
 - (A) Fetal alcohol syndrome;
 - (B) Neonatal abstinence syndrome; or
 - (C) any amount, including a trace amount of a controlled substance, a legend drug, or a metabolite of a controlled substance or legend drug in the child's body, including the child's blood, urine, umbilical cord tissue or meconium; and
- (2) The child needs care, treatment, or rehabilitation that:
 - (A) the child is not receiving; or
 - (B) is unlikely to be provided or accepted without the coercive intervention of the court.⁶⁶

The statute specifically defines maternal controlled substance use during pregnancy as conduct that can cause a child to be deemed a victim of abuse or neglect.⁶⁷ Marijuana is a Schedule I Narcotic in Indiana.⁶⁸ Therefore, any trace amount of THC detected in a newborn satisfies section 31-34-1-10.

The judicial intervention condition of a Child in Need of Services statute is the most difficult to prove in cases of marijuana-positive infants. There is little uniformity among Indiana courts in whether prong three is met in cases in-utero marijuana exposure.⁶⁹ Although sole marijuana use with no aggravating factors is unlikely to meet the threshold of prong three, judges have vast discretion in a CHINS determination. Many times, the judge will adjudicate the child as a child in need of services if the parent is low income, has a prior criminal history, has a prior history of substance use, or has had any contact with DCS in the past.⁷⁰

65. IND. CODE § 31-34-12-3 (2024); *see also* A.C. v. Ind. Dep't of Child Servs., 198 N.E.3d 1, 12 (Ind. Ct. App. 2022).

66. IND. CODE § 31-34-1-10 (2024).

67. *Id.*

68. IND. CODE § 35-48-2-4(d)(22) (2024).

69. *See* J.J. v. Ind. Dep't of Child Servs. (*In re* K.S.), 78 N.E.3d 740, 745 (Ind. Ct. App. 2017) (reversed lower court's finding of CHINS); D.V. v. Ind. Dep't of Child Servs. (*In re* B.V.), 110 N.E.3d 437, 441 (Ind. Ct. App. 2018) (reversed lower court's finding of CHINS due to DCS support of the reversal).

70. *See* Roark v. Roark, 551 N.E.2d 865, 872 (Ind. Ct. App. 1990) (holding evidence of injury to other children not involved in the current case is admissible); *see also* *In re* J.L.V., Jr., 667 N.E.2d 186, 190 (Ind. Ct. App. 1996) (finding that evidence of mother's prior involvement with DCS was admissible for a case involving a latter born child); *In Re* K.S., 78 N.E.3d at 743 (discussing mother's housing status).

2. Legislative History of § 31-34-1-10

The current Indiana Code section 31-34-1-10 was adopted in 1997.⁷¹ Prior to 1997, Indiana did not include any language classifying the mere presence of any amount of a controlled substance as evidence of a child being a child in need of services.⁷² Instead, the statute required that the child either be addicted to the controlled substance upon birth or born with injury or developmental issues caused or aggravated by the mother's use of the controlled substance during pregnancy.⁷³ Similarly to the current version of the statute, the pre-1997 code also required that the child need the coercive intervention of the court to justify involvement.⁷⁴

The current code section conflates any use of a controlled substance during pregnancy with abuse while the pre-1997 code focused more on the harms of use when determining abuse.⁷⁵ Although the current code section requires DCS to show the need for the coercive intervention of the court to support a CHINS adjudication,⁷⁶ this broad language allows for nonuniform application depending on the jurisdiction or judge hearing the case. However, the harm-centered language of the pre-1997 statute ensures that evidence of the infant's injury or addiction to a controlled substance must be shown by DCS in CHINS cases.⁷⁷

Indiana's purpose when writing the 1997 family law code was to present the code "in a style that is clear, concise, and easy to interpret and apply."⁷⁸ However, it is unclear why the Indiana Legislature chose to change the language of the statute in 1997. One possible explanation is that infant drug testing did not become common until the mid-1980s⁷⁹ and the Indiana Legislature added the "trace amount" language to reflect the new capabilities of drug testing procedures. Wide-spread infant drug testing was a direct response from the War on Drugs and the panic caused by the "crack baby" epidemic of the 1980s.⁸⁰ The "crack baby" epidemic was a period of United States history which promoted the idea that mothers, predominantly Black mothers, who used crack cocaine were substantially harming their infants.⁸¹ The "crack baby" panic not only led to mass infant drug testing procedures, but also resulted in many states passing

71. IND. CODE § 31-34-1-10 (2024).

72. See IND. CODE § 31-6-4-3.1 (1996) (repealed).

73. *Id.*

74. *Id.*

75. IND. CODE § 31-34-1-10 (2024); cf. IND. CODE § 31-6-4-3.1(1996) (repealed).

76. IND. CODE § 31-34-1-10 (2024).

77. IND. CODE § 31-6-4-3.1 (1996) (repealed).

78. *Id.*

79. Theresa Kurtz & Marcela C. Smid, *Challenges in Perinatal Drug Testing*, 140 J. OBSTETRICS & GYNECOLOGY 163, 163 (2022).

80. *Id.*

81. Katharine McCabe, *Criminalization of Care: Drug Testing Pregnant Patients*, 63 J. HEALTH & SOC. BEHAV. 162, 163 (2022).

laws to include prenatal substance use as a form of child abuse.⁸² Although it is unclear if the “crack baby” panic and subsequent availability of infant drug testing influenced the Indiana Legislature, the historical context reflects the government’s views and attitudes towards prenatal substance use in the 1990s.

D. Application of the Law

1. Hospital Policies

Generally, there are three types of drug testing procedures for infants: meconium, umbilical cord, and urine testing. Meconium is a substance passed by a newborn during his or her first bowel movement.⁸³ Meconium testing is an extremely accurate method for drug testing⁸⁴ and the test can generally detect maternal marijuana use from twenty-four weeks gestation to birth.⁸⁵ Umbilical cord testing is also extremely accurate for infant drug testing, however, it differs from meconium as it will not reveal positives for any drug given to the infant post-birth.⁸⁶ Similarly to meconium, an umbilical cord test will reveal maternal marijuana use from twenty-four weeks gestation to birth.⁸⁷ Lastly, urine testing is more difficult to administer on newborn patients⁸⁸ and the method only shows maternal marijuana use from thirty-two weeks gestation to birth.⁸⁹ Therefore, it is recommended that hospital staff primarily utilize meconium or umbilical cord testing.⁹⁰

In Indiana, hospitals have discretion to determine their own drug testing policies which leads to large discrepancies as to which individuals are tested, how they are tested, and when they are tested. In 2018, IU Health assessed and evaluated all pregnant patients on an individual basis.⁹¹ Conversely, in 2018 at Community Health Network, all pregnant individuals were drug tested upon being admitted for delivery and the infant was automatically drug tested with

82. *Id.*

83. Edward C. Maynard et al., *Meconium for Drug Testing*, 145 AM. J. DISEASES CHILD. 650, 652 (1991).

84. *Id.*

85. COLO. DEP’T. PUB. HEALTH & ENV’T, *Marijuana Pregnancy and Breastfeeding Guidance for Colorado Health Care Providers*, (Mar. 18, 2015), <https://wicworks.fns.usda.gov/sites/default/files/media/document/MJPregBreastfeedingGuidelines.pdf> [https://perma.cc/JVS6-Z3EG].

86. Kendra L. Palmer et al., *Evaluating a Switch from Meconium to Umbilical Cord Tissue for Newborn Drug Testing: A Retrospective Study at an Academic Medical Center*, 50 J. CLINICAL BIOCHEMISTRY 255, 256 (2017).

87. COLO. DEP’T. PUB. HEALTH & ENV’T, *supra* note 82, at 1.

88. Maynard et al., *supra* note 83, at 650.

89. COLO. DEP’T. PUB. HEALTH & ENV’T, *supra* note 85, at 1.

90. Maynard et al., *supra* note 83, at 651.

91. Nina Criscuolo, *Marijuana and Mothers-to-be: Potential Impacts and How Local Hospitals are Tracking Drug Use*, WISHTV (Jan. 11, 2018, 8:03 AM), <https://www.wishtv.com/news/marijuana-and-mothers-to-be-potential-impacts-and-how-local-hospitals-are-tracking-drug-use/> [https://perma.cc/G32X-E5SM].

either an umbilical cord or meconium screen upon a positive maternal test.⁹² St. Vincent also universally screened all pregnant individuals upon admittance in 2018, however, if a pregnant woman did not consent to testing, the infant's umbilical cord was automatically tested.⁹³ Lastly, Franciscan Health only screened pregnant women who exhibited suspicious behaviors, had unexplained separation of the placenta from the uterine lining, had unexplained fetal growth issues, and did not seek prenatal care before birth in 2018.⁹⁴ A positive maternal test resulted in automatic umbilical cord testing on the infant per the policy.⁹⁵

Indiana law bars hospital providers from releasing the results of a verbal substance use screening, a urine test, or a blood test provided without the pregnant individual's consent to law enforcement or DCS.⁹⁶ Nevertheless, the Indiana Perinatal Quality Improvement Collaborative (IPQIC) recommends that providers perform an umbilical cord screen on all infants whose parent has a positive verbal screen based on a drug use questionnaire.⁹⁷ Once the infant tests positive, the mandatory reporting statute is triggered and the hospital must report to DCS.⁹⁸ The mandatory reporting statute does not allow any discretion and healthcare providers are required to report the positive-THC result regardless of their interactions with the patient, the health of the infant, or their knowledge of safety of the home.⁹⁹ This lack of discretion is harmful because it places a blanket punishment on all families, regardless of the effect on the infant or safety of the home.

2. DCS Policies

The Department of Child Services (DCS) governs how cases of marijuana-positive infants are investigated by the state of Indiana.¹⁰⁰ All cases begin with a report of abuse to the DCS hotline.¹⁰¹ A hotline report is statutory requirement if any individual has reason to believe a child is a victim of abuse or neglect.¹⁰² Hospital staff have a higher standard; any member of hospital staff must

92. *Id.*

93. *Id.*

94. *Id.*

95. *Id.*

96. IND. CODE § 25-1-9-22 (2024).

97. Deborah Evert, *Indiana Efforts to Address Perinatal Substance Use*, IND. PERINATAL QUALITY IMPROVEMENT COLLABORATIVE 9 (Aug. 27, 2019), [https://www.ihaconnect.org/Resources/Public/Patient Safety/2019 PSU Conference/IPQIC - Community HN slides to share.pdf](https://www.ihaconnect.org/Resources/Public/Patient%20Safety/2019%20PSU%20Conference/IPQIC%20Community%20HN%20slides%20to%20share.pdf) [https://perma.cc/58AA-VPFS].

98. *See* IND. CODE § 31-33-5-1 (2024).

99. *See id.*

100. IND. CODE § 31-25-2-11 (2024).

101. *See* IND. CODE § 31-33-8-1(c) (2024); *see also* *Indiana Child Abuse and Neglect Hotline*, IND. DEP'T OF CHILD SERVS. <https://www.in.gov/dcs/contact-us/child-abuse-and-neglect-hotline/> [https://perma.cc/P5DG-2C9P] (last visited Dec. 28, 2024).

102. IND. CODE § 31-33-5-1 (2024).

immediately notify DCS or law enforcement of suspected abuse.¹⁰³ There is no discretion permitted by law for hospital personnel or individuals to abstain from calling in a report even if they believe DCS involvement is not necessary. It would be beneficial for a provider to have discretion when to call in these situations because a marijuana-positive test does not equate to abuse. Therefore, allowing the provider to use their best judgment based on their expertise and experience saves not only valuable DCS resources but protects the family from unnecessary intrusion by the agency.

Once the report is received by DCS, the Department is required to make a prompt and thorough assessment.¹⁰⁴ Once this assessment is completed and the family has been investigated, DCS will either substantiate the report if they believe enough evidence has been presented to support the allegations or unsubstantiate if the allegations are not supported by evidence.¹⁰⁵ The assessment manager who investigates the abuse must show by a preponderance of the evidence that the allegations are substantiated.¹⁰⁶ The DCS manual states that a single positive drug screen should not be considered an automatic CHINS, however, information relating to the impact of the drug use on the child and home environment should be used to make a determination on a case-by-case basis.¹⁰⁷ Nevertheless, the DCS manual specifically excludes § 31-34-1-10 from this policy.¹⁰⁸ Under the policy, a positive drug screen supports a substantiation for a drug born infant, encouraging case managers to ignore the coercive need for court intervention condition of the statute.¹⁰⁹ Such broad language gives assessment workers wide discretion on whether or not CHINS would be found at the assessment stage. Since every individual has different biases and attitudes towards marijuana use, unequal application of the law and treatment to the families occurs throughout the state and even within counties.

Once a report has been substantiated, a parent has thirty days after the notice of substantiation to request an administrative review of the assessment.¹¹⁰ DCS will then notify the parent if their appeal will be heard at least ten days before

103. *Id.* § 2.5.

104. IND. CODE § 31-33-8-6 (2024).

105. *Id.* § 12.

106. IND. DEP'T OF CHILD SERVS., INDIANA DEPARTMENT OF CHILD SERVICES CHILD WELFARE POLICY: MAKING AN ASSESSMENT FINDING 1 (2020) [hereinafter, MAKING AN ASSESSMENT FINDING], <https://www.in.gov/dcs/files/4.22-Making-an-Assessment-Finding.pdf> [https://perma.cc/H3W3-BG97].

107. *Id.* at 6.

108. IND. DEP'T OF CHILD SERVS., INDIANA DEPARTMENT OF CHILD SERVICES CHILD WELFARE POLICY: DRUG SCREENING IN ASSESSMENTS 1 (2022) [hereinafter, DRUG SCREENING IN ASSESSMENTS], <https://www.in.gov/dcs/files/4.40.pdf> [https://perma.cc/4ZNW-53BP].

109. *See id.*

110. IND. DEP'T OF CHILD SERVS., INDIANA DEPARTMENT OF CHILD SERVICES CHILD WELFARE MANUAL: ADMINISTRATIVE APPEAL HEARINGS 3 (2013) [hereinafter, ADMINISTRATIVE APPEAL HEARINGS], https://www.in.gov/dcs/files/2.05_Administrative_Appeal_Hearings.pdf [https://perma.cc/AV7G-V4UV].

DCS's chosen date of hearing.¹¹¹ The appeal is quasi-judicial and conducted "in the same manner as if it were preparing for a CHINS Juvenile Court Fact Finding Hearing."¹¹² Administrative reviews very rarely happen after a substantiation. The quasi-judicial nature of the hearing makes it difficult for a parent to prepare on short notice without the aid of legal counsel. Impoverished families are over forty times more likely to enter the child welfare system compared to middle class families¹¹³ and many of these families will not have the financial resources to hire counsel to fight a substantiation.

If a report is substantiated and DCS determines that juvenile court involvement is necessary, DCS files a CHINS petition.¹¹⁴ At the initial hearing, the parent has the opportunity to admit or deny the allegations in the petition.¹¹⁵ The court considers the parent's testimony and all relevant evidence presented to determine whether the child will be found CHINS under the law. If the court finds that the child is not a CHINS, the child will be discharged and the substantiation will be removed from the parents' record within ten working days.¹¹⁶ If CHINS is found, the court may order removal, coercive intervention, or a period of informal adjustment. After CHINS adjudication, the court will hold a dispositional hearing, which creates a safety plan and orders court-mandated services that must be completed by the parents.¹¹⁷ Commonly in cases of marijuana-positive infants, the court will order the mother to participate in random drug screening, which may range in frequency from twice a week to monthly depending on DCS's recommendation.¹¹⁸

3. Judicial Interpretation of § 31-34-1-10

There is no uniformity in how lower Indiana courts respond to cases of marijuana-positive infants. Juvenile courts have wide discretion during the CHINS adjudication process, which creates inconsistencies on how marijuana use is treated under the child abuse statutes. Juvenile court judges in some counties will remove the child from mother's care for prenatal marijuana use,¹¹⁹

111. *Id.* at 1.

112. *Id.* at 4.

113. *Family and Child Well-Being System: Economic & Concrete Supports as a Core Component*, CHAPIN HALL UNIV. CHI. (Apr. 2021), <https://www.in.gov/dcs/files/Economic-Supports-deck.pdf> [<https://perma.cc/2WTS-KUY2>].

114. IND. CODE § 31-33-14-1 (2024).

115. *Id.* § 31-34-10-6.

116. *Id.* § 31-33-26-15(a)(1).

117. *Id.* § 31-34-19-1(a).

118. IND. DEP'T OF CHILD SERVS., SERVICE STANDARD INDIANA DEPARTMENT OF CHILD SERVICES RANDOM DRUG TESTING, [hereinafter, RANDOM DRUG TESTING] <https://www.in.gov/dcs/files/27-Random-Drug-Testing.pdf> [<https://perma.cc/69SH-UYLQ>] (last visited Sept. 28, 2024).

119. See H.G. v. Ind. Dep't of Child Servs. (*In re L.K.*), No. 23A-JC-1249, 2024 Ind. App. LEXIS 183, at *2 (Ind. Ct. App. 2024); see also D.V. v. Ind. Dep't of Child Servs. (*In re B.V.*),

while others will reject such arguments.¹²⁰

However, recent decisions of the Indiana Court of Appeals demonstrate that mandatory DCS involvement in marijuana-positive infants should be reassessed. In 2015, the Indiana Court of Appeals found that a showing of a marijuana-positive meconium test did not alone show an endangerment to the child, which satisfies the need for the coercive intervention of the court.¹²¹ Furthermore, in 2017, a separate panel of the Indiana Court of Appeals held that a mother's marijuana use two months before the birth of her infant did not alone satisfy prong two of section 31-34-1-1,¹²² requiring that DCS show the "child needs care, treatment, or rehabilitation that... is unlikely to be provided or accepted without coercive intervention of the court."¹²³ The Indiana Court of Appeals is clear: there must be a showing of "specific evidence that the marijuana itself or Mother's use of it present[s] a serious danger to the Children,"¹²⁴ and mother's use of marijuana during pregnancy is not considered sufficient evidence to satisfy this standard.¹²⁵ Importantly, the sole issue of marijuana use, "whether isolated or habitual" is not enough to support a CHINS finding.¹²⁶

Although the Indiana Court of Appeals has held marijuana use does not alone constitute a CHINS adjudication, DCS and juvenile courts still continue to use a positive marijuana test to justify family intervention.¹²⁷ There appears to be a trend in which some courts use the positive marijuana test as their primary reason to be involved in impoverished families who do not satisfy the standard to fit into other abuse or neglect statutory categories. In 2015, Judge Baker writing for the Indiana Court of Appeals stated: "the mere fact of an unemployed parent does not make a CHINS. The mere fact of a family on food stamps does not make a CHINS. Even the mere fact of a family living in a shelter while seeking stable housing does not make a CHINS."¹²⁸

However, the factors listed by Judge Baker in his 2015 opinion are still used by DCS to justify a CHINS petition. For example, DCS filed a CHINS petition

110 N.E.3d 437, 439 (Ind. Ct. App. 2018) (reversing trial court finding of CHINS and removal order for prenatal marijuana use).

120. See *J.J. v. Ind. Dep't of Child Servs. (In re K.S.)*, 78 N.E.3d 740, 745 (Ind. Ct. App. 2017).

121. *A.M. v. Ind. Dep't of Child Servs. (In re S.M.)*, 45 N.E.3d 1252, 1256 (Ind. Ct. App. 2015).

122. *J.J.*, 78 N.E.3d at 745.

123. IND. CODE § 31-34-1-1 (2017).

124. *A.M. v. Ind. Dep't of Child Servs. (In re Ad.M.)*, 103 N.E.3d 709, 714 (Ind. Ct. App. 2018).

125. *Id.* (citing *A.M. v. Ind. Dep't of Child Servs. (In re S.M.)*, 45 N.E.3d at 1255).

126. *E.T. & T.T. v. Ind. Dep't of Child Servs.*, No. 21A-JC-203, 2021 Ind. App. LEXIS 532, at *20 (Ind. Ct. App. June 23, 2021).

127. See *J.J.*, 78 N.E.3d at 745 (reversing a lower court's CHINS adjudication for mother's marijuana use and unstable housing situation).

128. *A.M. v. Ind. Dep't of Child Servs. (In re S.M.)*, 45 N.E.3d 1252, 1256 (Ind. Ct. App. 2015).

against a mother predominantly for her marijuana use, a single incident of domestic violence between mother and father, and having a cluttered home with sporadic electricity outages.¹²⁹ The Court of Appeals reversed the lower court's CHINS adjudication because the mother had already remedied the home and domestic violence issues before the CHINS petition was even filed by DCS.¹³⁰ This case illustrates that DCS continues to substantiate on marijuana cases, even after the Court of Appeals has rejected such measures.

Another example is a case where an infant tested positive for marijuana at birth and the mother alleged, she did not know she was pregnant until she was twenty-six weeks along and immediately stopped use once she discovered her pregnancy.¹³¹ Although the family case manager found that there was adequate food, working utilities, and appropriate cleanliness in the home, there were seven people living in the apartment.¹³² The living arrangements combined with the family case managers' "number one issue" of the marijuana positive birth led to DCS filing a CHINS petition.¹³³ This 2009 panel of the Indiana Court of Appeals ultimately upheld the CHINS adjudication.¹³⁴ Judge May of the Indiana Court of Appeals served on the panel for this 2009 case and also served on the 2017 panel which heard *J.J. v. Indiana Department of Child Service (In re K.S.)*, a case that reached the opposite conclusion and held mother's use of marijuana during pregnancy is not justification to support a CHINS adjudication.¹³⁵ Judge May's decisions in these two cases reflect the Indiana Court of Appeals' changing attitude towards this issue and further illustrates DCS's continued efforts to involve the Department in the families of marijuana-positive infants.

Even though the Court of Appeals has clearly stated that marijuana-use alone during pregnancy is not enough to justify DCS involvement, DCS will remove a child to foster care for sole marijuana use. In 2022, Madison County, Indiana DCS removed an infant and placed it in foster care due to the sole issue of mother's use of THC products during pregnancy.¹³⁶ Furthermore, the decision to place the child in foster care occurred after the mother testified that she used legal Delta-8 purchased in Indiana gas stations.¹³⁷ The Court of Appeals in their 2024 opinion reversed the trial court's CHINS finding.¹³⁸ The Court rejected DCS's position and held that DCS provided no evidence on how the child was endangered by the marijuana use nor any evidence why the child needed the

129. *A.M. v. Ind. Dep't of Child Servs. (In re Ad.M.)*, 103 N.E.3d at 711–12.

130. *Id.* at 715.

131. *In re B.C. v. Marion Cnty. Dep't of Child Servs.*, No. 49A05-0806-JV-320, 2009 Ind. App. LEXIS 187, at *2 (Ind. Ct. App. Jan. 20, 2009).

132. *Id.* at *3.

133. *Id.*

134. *Id.* at *12–13.

135. 78 N.E.3d 740, 745 (Ind. Ct. App. 2017).

136. *H.G. v. Ind. Dep't of Child Servs. (In re L.K.)*, No. 23A-JC-1249, 2024 Ind. App. LEXIS 183, at *2–4 (Ind. Ct. App. Feb. 19, 2024).

137. *Id.*

138. *Id.* at *11.

coercive intervention of the court.¹³⁹ This separate panel of the Court of Appeals relied on Judge Baker's 2015 precedent: a "[m]other's ingestion of THC while pregnant and THC in the [c]hild's umbilical cord at birth do not alone demonstrate [the] [c]hild is seriously endangered."¹⁴⁰

III. ANALYSIS

A. Why Is This Legal Scheme Harmful?

1. Stress on the Family Structure

A positive THC screen triggers DCS involvement, causing harm to the mother, infant, and outside family. Although the Indiana Court of Appeals has held that a THC-positive infant does not solely support a CHINS adjudication, DCS continues to substantiate such cases¹⁴¹ and send the families to court.¹⁴² When a report of neglect or abuse is substantiated on, this means that the agency has authenticated their preliminary finding of abuse or neglect.¹⁴³ Once a person receives a substantiation, they can no longer adopt a child, hold a teaching license, work in a childcare facility, or supervise children in an informal setting such as a school field trip.¹⁴⁴

Additionally, entering foster care can be detrimental to a child's mental state.¹⁴⁵ In the first years of life, children depend on stable caregivers to regulate "their physiology, attention, behavior, and emotions."¹⁴⁶ Young children who experience disruptions in caregiving stability can exhibit issues in behavioral function later in life.¹⁴⁷ During the first three to four years of life, a young child's brain develops its personality traits, learning processes, stress coping skills, and emotional regulation processes.¹⁴⁸ Stress from removal, even in a young child

139. *Id.*

140. *Id.* at *7–8.

141. See *In re A.A. v. Ind. Dep't of Child Servs.*, No. 21-A-JC-1671, 2022 Ind. App. LEXIS 19, at *2 (Ind. Ct. App. Jan. 13, 2022) (discussing a prior substantiation on the mother for prenatal marijuana use).

142. See IND. CODE § 31-33-8-12 (2024).

143. *Id.*

144. *DCS Substantiation Indiana*, BANKS & BROWER, LLC (Sept. 10, 2017) <https://banksbrower.com/2017/09/10/dcs-substantiation-indiana/> [https://perma.cc/WL2N-8FYX].

145. AM. ACAD. OF PEDIATRICS COMM. ON EARLY CHILDHOOD, ADOPTION, AND DEPENDENT CARE, *Developmental Issues for Young Children in Foster Care*, 106 PEDIATRICS 1145, 1146 (2000).

146. Mary Dozier et al., *Infants and Toddlers in Foster Care*, 7 CHILD DEV. PERSPS. 166, 167 (2013).

147. *Id.* at 168.; see also Cynthia V. Healey & Philip A. Fisher, *Children in Foster Care and the Development of Favorable Outcomes*, 33 CHILD YOUTH SERV. REV. 1822, 1832 (2012).

148. AM. ACAD. OF PEDIATRICS COMM. ON EARLY CHILDHOOD, ADOPTION, AND DEPENDENT CARE, *supra* note 145, at 1145.

or infant, can impair this brain development.¹⁴⁹ Due to the potential severe developmental consequences, a child should not be removed from his or her parent's care unless the potential abuse or neglect from the parent outweighs the potential developmental consequences resulting from removal.

Racial disparities also play a role in an analysis of harm from child welfare involvement. The child welfare services system throughout the United States more often negatively impacts impoverished, people of color.¹⁵⁰ Black children are more likely to experience both child abuse investigations and removal from their parents compared to White children.¹⁵¹ 24 percent of child abuse or neglect reports were made for Black children, and Black children account for 21 percent of those entering the foster care system.¹⁵² Rates of removal to the foster care system are even higher for Indigenous children; an Indigenous mother is four times more likely to have their children removed compared to non-Indigenous parents.¹⁵³ Child services involvement disrupts the family structure through "changes in residence, parental employment, and social support" which negatively impacts child development by causing stress and conflicts among parents.¹⁵⁴ Parents of removed children also experience higher rates of "depression, substance use, physician visits for mental illness, and prescriptions of psychotropic medications."¹⁵⁵ Overall, child services involvement harms both the parents and the infants involved, and these harms should be avoided when the child is not in danger of abuse or neglect.¹⁵⁶

Even after the Court of Appeals rejected CHINS adjudication for in-utero marijuana exposure in 2015, removal to foster care is still currently an option for DCS in such cases. In 2022, DCS in Madison County, Indiana removed an infant and placed the baby in foster care due to the sole issue of mother's use of THC products during pregnancy.¹⁵⁷ Furthermore, the decision to place the child in foster care occurred after the mother testified that she used legal Delta-8 purchased in Indiana gas stations.¹⁵⁸ The Court of Appeals in their 2024

149. *Id.*

150. *US: Child Welfare System Harms Families*, HUM. RTS. WATCH (Nov. 17, 2022, 12:01 AM), <https://www.hrw.org/news/2022/11/17/us-child-welfare-system-harms-families> [https://perma.cc/6NQ9-ZJ7S].

151. *Id.*

152. *Id.*

153. *Id.*

154. Sharon H. Bzostek & Lawrence M. Berger, *Family Structure Experiences and Child Socioemotional Development During the First Nine Years of Life: Examining Heterogeneity by Family Structure at Birth*, 54 *DEMOGRAPHY* 513, 516 (2017).

155. Kathleen S. Kenny, *Mental Health Harm to Mothers When a Child is Taken by Child Protective Services: Health Equity Considerations*, 63 *CAN. J. PSYCHIATRY* 304, 304 (2018).

156. See *A.M. v. Ind. Dep't of Child Servs. (In re S.M.)*, 45 N.E.3d 1252, 1256–57 (Ind. Ct. App. 2015) (stating that the Indiana Department of Child Services should not focus its time and effort on cases of marijuana-positive infants).

157. *H.G. v. Ind. Dep't of Child Servs. (In re L.K.)*, No. 23A-JC-1249, 2024 Ind. App. LEXIS 183, at *2–4 (Ind. Ct. App. Feb. 19, 2024).

158. *Id.*

unpublished opinion reversed the trial court's CHINS finding.¹⁵⁹ The court rejected DCS's position and held that DCS provided no evidence on how the child was endangered by the marijuana use nor any evidence why the child needed the coercive intervention of the court.¹⁶⁰ This separate panel of the Court of Appeals relied on Judge Baker's 2015 precedent: a "[m]other's ingestion of THC while pregnant and THC in [the] [c]hild's umbilical cord at birth do not alone demonstrate that [the] [c]hild is seriously endangered."¹⁶¹

2. Physician-Patient Distrust

The hospital policies on drug testing disadvantage low-income people of color.¹⁶² Since IU Health and Franciscan Health do not universally screen mothers, the hospital staff independently determines which individuals are suspected drug users. A 2023 published study found that 43.3% of all drug positive infants were positive solely for THC at a Midwest hospital.¹⁶³ Between 2014-2020, hospital staff ordered drug tests for Black newborns at a rate of 7.3% compared to just 1.9% of White newborns even though 71.6% of those admitted for delivery to the hospital were White.¹⁶⁴ The hospital's bias for drug testing Black mothers is not unique. After being admitted for delivery, Black women are at least 1.5 times more likely to be drug tested than non-Black women.¹⁶⁵

Race is not associated with whether a mother will test positive for an illegal drug.¹⁶⁶ Nevertheless, Black mothers are tested at much higher rates than White mothers. IU Health and Franciscan Health's policies allowing for hospital staff to independently determine which parents are drug screened furthers the disparity. Human biases and racist attitudes towards Black families are likely to contribute to the decision to drug test a pregnant parent or infant without a set procedure for when these individuals are drug tested.¹⁶⁷ Black, pregnant women "experience maltreatment and preventable adverse outcomes in [maternal] healthcare settings at higher rates than white women."¹⁶⁸ Furthermore, Black parents are four times more likely to be reported to child protective services

159. *Id.* at *11.

160. *Id.*

161. *Id.* at *7–8.

162. *See generally supra* Sec. D1.

163. Sebastian Schoneich et al., *Incidence of Newborn Drug Testing and Variations by Birthing Parent Race and Ethnicity Before and After Recreational Cannabis Legalization*, 6 JAMA NETWORK OPEN 1, 4–6 (2023).

164. *Id.* at 5.

165. Hillary Veda Kunins et al., *The Effect of Race on Provider Decisions to Test for Illicit Drug Use in the Peripartum Setting*, 16 J. WOMEN'S HEALTH 245, 255 (2007).

166. *Id.*

167. *See generally* Hayley R. Price et al., *Screening Pregnant Women and Their Neonates for Illicit Drug Use: Considerations of the Integrated Technical, Medical, Ethical, Legal, and Social Issues*, 9 FRONTIERS PHARMACOLOGY 961, 961 (2018).

168. Brittany D. Chambers et al., *Clinicians' Perspectives on Racism and Black Women's Maternal Health*, 3.1 WOMEN'S HEALTH REPS. 476, 480 (2022).

from a hospital provider compared to White parents.¹⁶⁹ Hospital policies which allow for staff to independently determine who will be drug tested result in high harm for Black parents and allows for Black women to face punitive consequences for maternal marijuana use even though rates of use are similar among racial groups.¹⁷⁰

An additional consequence of the current legal and policy framework is patient mistrust of medical providers. Physician mandatory reporting creates an “adversarial relationship” between the provider and patient and encourages the patient to either not be truthful about their substance use or avoid prenatal care altogether.¹⁷¹ Pregnant mothers who are using marijuana are put in a difficult position, they can: (1) be honest with their doctors and have their infants unconsensually drug tested; (2) refuse prenatal care and risk adverse health outcomes; or (3) lie to their providers about their substance use. Dishonesty is the only method of ensuring the infant is not drug tested based on the mother’s interactions with their medical providers.

It is necessary to foster trust between doctor and patient to promote the health and welfare of both mother and infant.¹⁷² Prenatal care “greatly reduces” risks of low birth weight and prematurity,¹⁷³ two health risks with potential connections to prenatal marijuana use.¹⁷⁴ The American College of Obstetricians and Gynecologists strongly recommends healthcare providers counsel all pregnant individuals about the potential negative effects of maternal marijuana use;¹⁷⁵ however, Indiana providers are unable to follow their guidance due to the mandatory reporting law. If the physician learns of marijuana use and counsels the pregnant patient to abstain, the physician must still drug test the infant under the hospital’s policies. Such an act breaks the parent’s confidence and trust based on their disclosure. Dismantling the punitive system of maternal drug testing will improve access to prenatal care and substance use treatment which will result in improved health outcomes for both the mother and infant involved.¹⁷⁶

169. *Id.* at 481.

170. AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, OPPOSITION TO CRIMINALIZATION OF INDIVIDUALS DURING PREGNANCY AND POSTPARTUM PERIOD STATEMENT OF POLICY (Dec. 2020), <https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/opposition-criminalization-of-individuals-pregnancy-and-postpartum-period> [https://perma.cc/6D64-NN43].

171. AM. COLL. OBSTETRICIANS & GYNECOLOGISTS COMMITTEE ON HEALTH CARE FOR UNDERSERVED WOMEN, SUBSTANCE ABUSE REPORTING AND PREGNANCY: THE ROLE OF THE OBSTETRICIAN-GYNECOLOGIST: COMMITTEE OPINION 473 (Jan. 2011), <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2011/01/substance-abuse-reporting-and-pregnancy-the-role-of-the-obstetrician-gynecologist> [https://perma.cc/M9PD-HA2Z].

172. *Id.*

173. *Id.*

174. Marroun et al., *supra* note 13, at 1181.

175. COMM. OBSTETRIC PRAC., *supra* note 12, at 207.

176. Price et al., *supra* note 167, at 961.

3. DCS Burden

The financial costs of the child welfare system is immense. Yearly across the United States, direct public expenditures by state and local child welfare agencies total thirty-three billion dollars.¹⁷⁷ In Indiana, DCS requested \$931,492,447 from the State to continue their operations for the 2025 year.¹⁷⁸ The majority of this budget is used just to provide services for families in the child welfare system.¹⁷⁹

Furthermore, the DCS system faces numerous challenges. A 2018 report from Child Welfare Policy and Practice Group (CWG)¹⁸⁰ found a multitude of issues plaguing Indiana DCS. In this report, the group found Indiana DCS has an “exceptionally high rate of court involvement”, high staff caseloads, and uneven interpretation and implementation of policies across counties.¹⁸¹ Specifically, the number of court involved cases is double the national average, Indiana accepts more abuse and neglect reports than the national average, and in 2017 DCS spent \$24,933,487 just on drug testing and supplies.¹⁸² The group recommended broad legislation to solve the problems, however, much was not implemented. For example, it was recommended the Indiana Legislature “exclude neglect which is solely based on poverty or limited, one-time lapses in parental judgement”¹⁸³ This has not been implemented by the Indiana Legislature as of 2023. Currently, there is no pending legislation in the 2024 session to address this issue. Furthermore, the report identified high staff caseloads and a major concern for the agency.¹⁸⁴ Although staff turnover rate dropped in 2019 after the CWG report, it currently is on the rise once more.¹⁸⁵ In 2022, DCS identified staffing as still a major concern due to losing 774 family case managers between January to November 2022 alone.¹⁸⁶ In the 2023 fiscal

177. *Family and Child Well-Being System: Economic & Concrete Supports as a Core Component*, *supra* note 113, at 14.

178. IND. DEP’T CHILD SERVS., DCS STATE BUDGET COMMITTEE PRESENTATION 16 (2022), <https://www.in.gov/sba/files/1.-Dept-of-Child-Services-Budget-Committee-Presentation.pdf> [<https://perma.cc/U4BQ-DG3K>].

179. *Id.*

180. The CWG is a private, non-profit organization which assists child welfare agencies throughout the country to create, design, and manage organizational changes to improve the agencies’ outcomes and practices. *See generally The Child Welfare Policy and Practice Group*, CAUSE IQ, <https://www.causeiq.com/organizations/the-child-welfare-policy-and-practice-group,721364474/> [<https://perma.cc/8RYU-3VBJ>] (last visited Mar. 7, 2024).

181. CHILD WELFARE POLICY & PRACTICE GROUP, EVALUATION OF THE INDIANA DEPARTMENT OF CHILD SERVICES 5 (2018).

182. *Id.* at 7.

183. *Id.* at 7, 89.

184. *Id.* at 30.

185. *Editorial: Case Manager Turnover Remains a Problem at DCS*, DAILY J. (Dec. 7, 2023), <https://dailyjournal.net/2023/12/07/editorial-case-manager-turnover-remains-a-problem-at-dcs/> [<https://perma.cc/2KXM-ACJ5>].

186. IND. DEP’T CHILD SERVS., *supra* note 178, at 13.

year, Indiana DCS saw a turnover of over one third of its statewide staff.¹⁸⁷

The CWG report also identified attitudes of family case managers, attorneys, and others in the Department which reflected an “increased prevalence of the assumption that a parent who uses any type of substance, particularly any that is illegal, is a ‘bad person’ and unsuitable as a parent.”¹⁸⁸ The group’s reviewers frequently heard references from DCS staff regarding a substance’s illegal status when determining case outcomes rather than discussions of impairment or child endangerment.¹⁸⁹ Furthermore, many case managers specifically stated that they felt DCS takes an “aggressive approach” to parental marijuana use when the same focus is not used for parental alcohol use.¹⁹⁰

Although case managers have identified DCS cultural issues which results in aggressive and unfair pursuit of marijuana cases in 2018, the State has not implemented any comprehensive reform to solve the issue. Furthermore, prenatal marijuana use is still a large factor in CHINS adjudications in the state, five years after the CWG report was released.¹⁹¹ It is unclear why the Indiana Legislature will not take action to lessen the burden on DCS regarding marijuana. Staffing and budget issues are high level concerns for the agency, therefore, removing marijuana use as an neglect/abuse indicator would free up time and resources for DCS staff to focus on more pressing cases. Furthermore, the Indiana Court of Appeals is clear in its precedent that marijuana use will not support a CHINS adjudication on appeal. The resources exerted by DCS to involve themselves in prenatal marijuana cases wastes the time and energy of the already over-burdened case managers, especially considering many of these cases will lose on appeal.

IV. POSSIBLE SOLUTIONS TO REDUCE HARM OF THE STATUTORY SCHEME

A. How Do Other States Approach This Issue?

Currently, twenty-four states have legalized recreational marijuana, and thirty-eight states have legalized medicinal marijuana.¹⁹² However, even legalized states differ in their approach to prenatal marijuana use. Indiana’s surrounding states of Ohio, Illinois, and Kentucky illustrate three different

187. *Editorial: Case Manager Turnover Remains a Problem at DCS*, *supra* note 185.

188. IND. DEP’T CHILD SERVS., *supra* note 178, at 55.

189. *Id.*

190. *Id.*

191. See *L.H. v. Ind. Dep’t of Child Servs.*, No. 22A-JC-730, 2022 Ind. App. LEXIS 1153, at *10 (Ind. Ct. App. Sept. 30, 2022) (explaining mother’s prenatal marijuana use and continued use post birth was a factor in her child’s removal); see also *Mother v. Ind. Dep’t of Child. Servs.* (*In re of F.F.*), No. 23A-JT-494, 2023 Ind. App. LEXIS 1430, at *2 (Ind. Ct. App. 2023) (discussing the original CHINS petition which alleged prenatal marijuana use as its first factor supporting removal).

192. *State Medical Cannabis Laws*, *supra* note 3.

approaches for child welfare services involvement in marijuana-positive infants.

Ohio legalized recreational marijuana on November 7, 2023.¹⁹³ In Ohio, child welfare services is statutorily barred from filing a complaint against a mother using a controlled substance during pregnancy if the mother: (1) enrolled in a drug treatment program before the twentieth week of pregnancy; (2) successfully completed the program or is in the process of successful completion; and (3) maintained her regularly scheduled appointments and prenatal care as recommended by a physician.¹⁹⁴ Furthermore, there is no comparable “trace amount” of a controlled substance language in the Ohio child abuse statutes and Ohio child welfare services has more discretionary power when choosing to file complaints compared to Indiana.

In Illinois, individuals who are mandatory child abuse reporters may report a pregnant individual with substance use disorder to the Department of Human Services for treatment.¹⁹⁵ Although Illinois legalized recreational marijuana in 2019,¹⁹⁶ the legislator includes “a spectrum of persistent and reoccurring problematic” cannabis use which results in “clinically significant impairment or distress” within their definition of substance use disorder.¹⁹⁷ However, the Illinois Cannabis Regulation and Tax Act expressly prohibits cannabis use from being the sole factor supporting an action by the child welfare agency.¹⁹⁸ Nevertheless, there are reports of judges and child welfare agency actors continuing to use marijuana as primary justification for child welfare agency involvement.¹⁹⁹

Lastly, Kentucky, a state which marijuana is illegal, includes in their definition of child abuse or neglect a parent which “creates or allows to be created a risk of physical or emotional injury... to the child by other than accidental means.”²⁰⁰ However, there is no trace amount language or reference to parental substance use in the statute. Nevertheless, Kentucky courts have extended this definition of abuse to prenatal marijuana use.²⁰¹ This statute is broader than Indiana’s because it does not expressly include prenatal substance use, allowing child welfare workers to use their discretion during child abuse

193. Samantha Hendrickson & Julie Carr Smith, *Adults Can Now Legally Possess and Grow Marijuana in Ohio – but There’s Nowhere to Buy it*, AP NEWS (Dec. 7, 2023, 6:11 PM), <https://apnews.com/article/ohio-legalized-recreational-marijuana-eb7fb8bc24d5f04e35cae89f491b3995> [<https://perma.cc/R2NZ-A2QR>].

194. OHIO REV. CODE ANN. § 2151.26(B) (1)-(3) (LexisNexis 2017).

195. 325 ILL. COMP. STAT. 5/7.3b (2019).

196. 410 ILL. COMP. STAT. 705/1-5 (2019).

197. 20 ILL. COMP. STAT. 301/1-10 (2019).

198. 410 ILL. COMP. STAT. 705/10-30 (2019).

199. Jaye R. Lindsay, *Illinois: Marijuana Consumers Still Face Discrimination in Family Court*, NORML (Feb. 19, 2021), <https://norml.org/blog/2021/02/19/illinois-marijuana-consumers-still-face-discrimination-in-family-court/> [<https://perma.cc/97X9-NQJD>].

200. KY. REV. STAT. ANN. § 600.020(a)(1)(2) (2022).

201. See *C.J.M. v. Cabinet for Health & Family Servs.*, 389 S.W.3d 155, 155-56 (Ky. Ct. App. 2012) (affirming a father’s termination of parental rights when the original complaint was due to the mother’s prenatal marijuana use).

investigations.

Indiana has uniquely rigid child abuse definitions compared to many other areas of the United States.²⁰² In fact, twenty-six states have no specific statute defining prenatal substance use as child abuse or neglect.²⁰³ In these twenty-six states, the legislators have chosen to generally “afford discretion to individual providers, hospitals, and other policy implementers to determine whether abuse is suspected,”²⁰⁴ rather than automatically requiring a punitive approach.

B. Hospital Policy Reform

Hospitals have the opportunity to be at the forefront of marijuana reform by amending their internal policies on marijuana-positive infants. Hospitals can either create a universal drug testing system, ban maternal drug testing, or counsel women regarding the harms of marijuana use during pregnancy whilst also working within the confines of section 31-34-1-10(c) and the mandatory reporting statute.²⁰⁵

One solution to decrease racism and biases, which lead to Black mothers being drug tested at higher rates, is to require all Indiana hospitals to drug test every individual who is admitted for delivery; Community Health currently follows this type of policy.²⁰⁶ Although universal drug testing would create an equitable system in which everyone, regardless of race, is treated the same in the hospital, this policy choice would heighten other types of harm to the parent and family. The American College of Obstetricians and Gynecologists opposes universal, mandated drug testing for pregnant women because the drug testing “disrupts bodily autonomy of the pregnant person and their newborn and is inconsistent with treating substance use disorder.”²⁰⁷ A universal drug testing policy would increase the harm to the family structure as it would cause more maternal marijuana use to be discovered and increase the reports to DCS. Furthermore, a universal system would not solve the issue of physician-patient mistrust because pregnant individuals will continue to “engage in behavior to avoid detection, including not presenting for prenatal care and attempting to deliver outside the hospital environment.”²⁰⁸ The risk of increasing harm from DCS involvement and encouraging unsafe prenatal and labor care makes universal drug screening an unwise policy decision.

A second potential solution is to ban maternal drug testing altogether.

202. See GA. CODE ANN. § 15-11-2 (2021) (Georgia has a similar statute to Indiana which defines prenatal abuse in part as the “presence of a controlled substance or a metabolite thereof in the newborn’s body, blood, urine, or meconium that is not the result of medical treatment”).

203. Alexander D. McCourt et al., *Development and Implementation of State and Federal Child Welfare Laws Related to Drug Use in Pregnancy*, 100 MILBANK Q. 1076, 1076 (2022).

204. *Id.*

205. IND. CODE § 31-33-5-1 (2024).

206. Criscuolo, *supra* note 91.

207. AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, *supra* note 170.

208. Price et al., *supra* note 167, at 961.

Banning maternal drug testing would solve the issues of DCS involvement, medical racism, and physician-patient mistrust because the hospital will never discover the marijuana use. Furthermore, an overall ban would conform to the College of Obstetricians and Gynecologists recommendation that health care providers encourage self-reporting substance use rather than utilizing drug testing procedures.²⁰⁹ Maternal drug testing supports a culture of fear surrounding prenatal health and banning the practice would encourage patients to seek prenatal care and increase healthy outcomes for the pregnant parent and infant in the context of maternal marijuana use.

However, banning maternal drug testing would not necessarily create the best outcomes for all pregnant mothers and infants. Although marijuana has not been connected to adverse health outcomes for infants, there are many other types of illegal substances which can cause severe health issues which healthcare workers must be aware of before birth. For example, infants exposed to methamphetamine have an increased chance of low birth weight, growth issues, and preterm delivery.²¹⁰ Furthermore, methamphetamine-exposed infants have a high chance of post-birth withdrawal symptoms including poor muscle control, poor appetite, jittery temperament, sleeping issues, and/or trouble breathing.²¹¹ In cases of methamphetamine exposure, it is critical that healthcare providers know the infant is methamphetamine-positive to provide care which could be lifesaving to the child.²¹² Banning maternal drug testing would prevent care for other types of drug exposure, so the harms associated with non-marijuana drug exposure potentially outweigh the harms of involvement for marijuana.

The last solution is for hospitals to amend their policies and counsel all pregnant patients about marijuana use without asking whether or not they partake in the substance. The hospitals can create a pamphlet and a small discussion about the potential risks of marijuana use and require that all patients are counseled about the risk during their prenatal appointments. If the healthcare providers are clear at the beginning of an appointment that they do not want an admission of use but only wish to provide resources and information regarding marijuana, this will not trigger the mandatory reporting statute.

This solution will solve the issues of DCS involvement, medical racism, and physician-patient mistrust since all patients, regardless of race, will receive the same information and counseling. Furthermore, it gives pregnant individuals an opportunity to learn about the potential risks of infant marijuana-exposure without being forced to admit use; however, without substantial change to hospital drug testing policies, this solution will not necessarily solve the inequalities in testing procedures. Pregnant Black mothers will still be tested at

209. AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, *supra* note 170.

210. *Mother to Baby Fact Sheets Methamphetamine*, MOTHERTOBABY (Jan. 2024) <https://mothertobaby.org/fact-sheets/methamphetamine/> [https://perma.cc/CS89-X6KZ].

211. *Id.*

212. *Id.*

higher rates than White individuals under individualized drug testing determination policies.²¹³ However, all pregnant mothers will receive the opportunity to learn about marijuana and decide whether to stop use without giving the hospital staff opportunity to suspect use via the patient's admission or inquiries into the potential harms of maternal marijuana use.

Although hospitals can amend their internal policies, such solutions do not change the root of the issue: state involvement. Hospitals are the first step in the cycle of the state's involvement for maternal marijuana use, however, hospitals cannot completely change the system through their actions. The only way to ensure DCS does not involve themselves in marijuana-positive infants is through legislative action.

C. DCS Reform

DCS also has opportunity to reform their internal practices to decrease rates of involvement in marijuana-positive infants. A potential solution is for DCS to focus solely on the need for the coercive intervention condition of the statute when investigating such cases.²¹⁴ Although this condition is supposed to be highly considered when investigating all cases, there is a lack of uniformity among the Department's case and assessment managers in what constitutes the need for coercive intervention. Current DCS procedure states, "[w]ith the exception of IC 31-34-1-10, [a] decision to substantiate or unsubstantiate an allegation should not be based solely on the existence or absence of substance."²¹⁵ This policy in itself supports the practice of substantiating all cases of drug-positive infants under section 31-34-1-10 and ignores the coercive intervention requirement under the code.

Instead of promoting a policy of substantiating all cases of drug-born infants, DCS could create a policy which emphasizes a need to show how the prenatal drug use creates an unsafe environment for the child. Such policy would more accurately reflect the requirements under the statute, align with the Indiana Court of Appeals opinions, and help promote the best interests of the child. However, such policy would not necessarily create uniform procedures throughout the State since different case and assessment managers in different offices may have opposing views on what conditions constitute coercive intervention. DCS needs clear direction from the Indiana legislature expressly excluding marijuana-positive infants from the statutory definition of a child in need of services to ensure that all offices throughout the State are treating such cases in a consistent manner.

213. See Criscuolo, *supra* note 91.

214. IND. CODE § 31-34-1-10 (2024).

215. DRUG SCREENING IN ASSESSMENTS, *supra* note 108, at 1 (emphasis added).

D. Amendment to the Statute

There are two possible solutions to reduce the harm of the State's involvement in marijuana-positive infants through legislative action. Firstly, Indiana could amend section 31-34-1-10(1)(c) to specifically exclude marijuana from the substances included in the definition of abuse or neglect. Under this solution, the statute section would read:

- (1) a child is a child in need of services if: . . .
(c) any amount, including a trace amount, of a controlled substance, a legend drug, or a metabolite of a controlled substance or legend drug in the child's body, including the child's blood, urine, umbilical cord tissue, or meconium,²¹⁶ *excluding the presence of any amount, including a trace amount, of marijuana or other forms of delta-9-tetrahydrocannabinol (THC).*

Amending the statute to exclude marijuana would be the simplest solution in reducing the harm from State involvement in marijuana-positive infants. One benefit of such a solution is that this language only affects in-utero marijuana exposure rather than a complete overhaul of how all controlled substances are treated under section 31-34-1-10. Adding a marijuana exception would ensure that marijuana-positive infants are excluded from the statute, thereby not triggering hospital mandatory reporting laws²¹⁷ and ending any form of statutorily required DCS involvement in affected families.

However, such an amendment would rigidly exclude marijuana from any DCS involvement no matter the outcomes. Although marijuana has no proven connection to any infant adverse health outcomes,²¹⁸ future research may change the current understanding of marijuana's effects during pregnancy. If so, a rigid exclusion of marijuana from the statute may become problematic if evidence of injury to the child is discovered. Furthermore, laws relating to marijuana traditionally fail in Indiana and any statute aiming to relax restrictions on the substance will most likely be met with resistance from Indiana Governor Holcomb and certain members of the Indiana legislature.²¹⁹

A second possible amendment to section 31-34-1-10 would be to change the statute back to its original pre-1997 version. This language would read:

216. IND. CODE § 31-34-1-10(1)(c) (2024).

217. IND. CODE § 31-33-5-1 (2024).

218. *See* COMM. OBSTETRIC PRAC., *supra* note 12, at 206–07; *see also* Metz et al., *supra* note 56, at 484.

219. *See Indiana Marijuana Laws*, INDIANA CANNABIS INFORMATION (2023), <https://indiana.cannabis.org/laws> [<https://perma.cc/9H69-A9XD>]; *see also* Brittany Carloni & Kayla Dwyer, *Ohio Voted to Legalize Recreational Marijuana. Why Indiana is Unlikely to do the Same*, INDYSTAR (Nov. 9, 2023 5:18 AM), <https://www.indystar.com/story/news/local/2023/11/09/indiana-unlikely-legalize-recreational-marijuana-despite-ohio-vote/71503838007/> [<https://perma.cc/6HAS-VA2C>].

A child is a child in need of services if: . . .

- (1) the child is born with:
 - (a) fetal alcohol syndrome
 - (b) An addiction to a controlled substance or a legend drug; or
- (2) The child:
 - (a) Has an injury;
 - (b) Has abnormal physical or psychological development; or
 - (c) Is at a substantial risk of a life threatening condition

that arises or is substantially aggravated because the child's mother used alcohol, a controlled substance, or a legend drug during pregnancy. . . .²²⁰

Repealing section 31-34-1-10 and replacing it with the pre-1997 code section ensures that the harm element of the mother's marijuana use is given great weight by DCS. Under this language, the mere presence of THC in the infant's system is not enough to satisfy any section of the statute. The infant must be born addicted to marijuana, which is not scientifically possible,²²¹ or have developmental issues due to the marijuana use.²²² Returning to this statutory language could potentially decrease the amount of families referred to DCS for marijuana-positive infants because marijuana has not been directly connected to adverse developmental outcomes nor infant addiction and withdrawal symptoms.²²³ Furthermore, this language allows for marijuana-positive infants born with health issues to potentially be considered CHINS if future scientific research finds developmental issues from in-utero marijuana exposure.

Nevertheless, the pre-1997 code section is not a perfect solution. Firstly, the language does not reflect the modern medical and scientific precision of the current language of section 31-34-1-10. Section 31-34-1-10 includes neonatal abstinence syndrome and types of drug testing procedures in its language,²²⁴ which informs healthcare providers of what types of tests and types of disorders should be included under the statute. Furthermore, the term "addiction" is not defined in the statute. Currently, healthcare providers consider an infant "addicted" to a substance if the infant suffers from neonatal abstinence syndrome.²²⁵ However, without a clear definition of "addiction" under the statute, interpretations of what constitutes addiction could result in nonuniform application of the statute depending on the healthcare provider, DCS assessment worker, or judge involved.

220. IND. CODE § 31-6-4-3.1 (1996) (replaced with IND. CODE § 31-34-1-10 (2024)).

221. Shukla & Doshi, *supra* note 11.

222. IND. CODE § 31-6-4-3.1 (1996) (replaced with IND. CODE § 31-34-1-10 (2024)).

223. See COMM. OBSTETRIC PRAC., *supra* note 12, at 206–07.

224. IND. CODE § 31-34-1-10 (2024).

225. *Neonatal Abstinence Syndrome*, STAN. MED. CHILDS. HEALTH, <https://www.stanfordchildrens.org/en/topic/default?id=neonatal-abstinence-syndrome-90-P02387> [https://perma.cc/3UHH-7NLD] (last visited Sept. 29, 2024).

V. PROPOSAL

The State's punitive approach towards prenatal marijuana use is neither decreasing the marijuana-positive births nor protecting the best interests of the child. Amending the code to exclude marijuana would promote honesty between patients and doctors, DCS efficiency, and healthy family outcomes. Furthermore, an amendment to section 31-34-1-10(c) excluding marijuana would end the requirement that healthcare providers must report marijuana-positive infants and allow them vital discretion in determining the needs of the child and family. In order to exclude marijuana while maintaining the majority of the statute's language, the amended statute should read:

- (1) a child is a child in need of services if: . . .
 - (c) any amount, including a trace amount, of a controlled substance, a legend drug, or a metabolite of a controlled substance or legend drug in the child's body, including the child's blood, urine, umbilical cord tissue, or meconium,²²⁶ *excluding the presence of any amount, including a trace amount, of marijuana or other forms of delta-9-tetrahydrocannabinol (THC).*

Maintaining the majority of the language of the current section 31-34-1-10(c) section ensures that other controlled substances which are scientifically proven to cause harm are still included in the statute. Furthermore, it allows DCS to focus its limited time and resources on cases of heroin, methamphetamine, fentanyl, and other dangerous drugs whose use substantially creates a high risk of abuse for the child after birth. Lastly, this proposed amendment would end the lower court's involvement in marijuana-positive infants and save the court's time, money, and resources when these cases are usually reversed upon appeal.

Nevertheless, an amendment excluding marijuana is likely to be met with push back from the Indiana Legislature. Bills regarding marijuana's legalization and decriminalization have been on the Indiana legislative docket for years but have never advanced, even when there has been bipartisan support.²²⁷ Furthermore, current Indiana governor Eric Holcomb strongly opposes marijuana's legalization because the federal government classifies it as a Schedule 1 narcotic.²²⁸ Although Holcomb's tenure as Indiana's governor will end in November 2024, his opinion on Indiana's legalization of marijuana is shared by other Indiana politicians. In the 2024 legislative session, a bipartisan

226. IND. CODE § 31-34-1-10(1)(c) (2024).

227. Kayla Dwyer, *Where Indiana's Candidates for Governor Stand on Marijuana Legalization*, INDYSTAR (last updated Jan. 8, 2024 2:33 PM), <https://www.indystar.com/story/news/politics/elections/2023/11/20/is-weed-legal-indiana-2024-governor-candidates-positions/71506905007/> [https://perma.cc/5NKW-7AAH].

228. *Id.*

bill authorized by Republican Senator Eric Bassler and Democrat Senator Rodney Pol has been introduced to legalize medical marijuana in Indiana upon the federal reclassification of marijuana off of the Schedule I narcotics list.²²⁹ In the DCS context, the Department continues to substantiate on cases of marijuana positive infants. Although the legislature enacted several recommendations by the CWG in their 2018 report on DCS,²³⁰ the legislative response was to increase DCS's budget to hire more family case managers rather than create policy instruments to reduce DCS involvement in low-risk families.²³¹ In the 2024 Indiana legislative session, there were no bills introduced regarding DCS's response to drug exposed infants and such reform is unlikely to occur in the near future.

VI. CONCLUSION

The rates of prenatal marijuana use are increasing in the United States.²³² Although the exact harms of marijuana exposure on infants are unclear, the government has a valid interest in promoting marijuana free pregnancies to ensure the health of mother and infant. However, the punitive approach taken by the Indiana Legislature creates more harm than good by adding stress to the family's structure through DCS involvement, creating distrust between mother and physician via mandatory reporting laws, and burdening the court system and DCS employees with such cases. The Indiana Court of Appeals has clearly held that evidence of marijuana in an infant cannot be the sole factor in supporting a CHINS adjudication.²³³ Since the Indiana Court of Appeals will not adjudicate a child CHINS for in-utero exposure to marijuana, the goal of promoting marijuana free pregnancies is better obtained by removing DCS involvement in such cases to allow for healthcare workers to engage in honest conversations with pregnant women about the risks of use. Amending Indiana Code § 31-34-1-10 to exclude marijuana furthers this goal and allows for medically informed prenatal care regarding marijuana use.

As Judge Baker stated in his 2015 Indiana Court of Appeals opinion, "DCS and the courts are overwhelmed with the growing number of CHINS cases statewide. All would be better served if the system focused its time, efforts, and

229. S.B. 294, 123rd Gen. Assemb., Second Reg. Sess. (Ind. 2024).

230. The Indiana legislature passed bills relating to support for foster care families, foster care children support, and an increased budget for DCS in response to the 2018 CWG report. See Abraham Hurt, *Holcomb Touts Improvements at Indiana Department of Child Services*, S. BEND TRIB. (June 16, 2019, 5:00 PM), <https://www.southbendtribune.com/story/news/2019/06/16/holcomb-touts-improvements-at-indiana-department-of-child-services/117179292/> [https://perma.cc/RN4V-A8GX].

231. See *id.* (the DCS's 2021 fiscal year budget was increased to more than 800 million dollars and a 25-million-dollar state surplus was redirected to the agency in 2018).

232. Young-Wolff et al., *supra* note 52, at 1745.

233. A.M. v. Ind. Dep't of Child. Servs. (*In re S.M.*), 45 N.E.3d 1252, 1265–57 (Ind. Ct. App. 2015).

resources on the families who really need them. This [family of a marijuana positive infant] does not.”²³⁴ Nearly nine years after Judge Baker’s opinion, it is time for the Indiana Legislature to statutorily ensure marijuana-exposed infants are best served through the healthcare system and end DCS’s involvement in their families.

234. *Id.*