

The WHO's First-Ever Critical Review of Cannabis:

A Mixture of Obvious Recommendations Deserving Support and Dubious Methods and Outcomes Requiring Scrutiny

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The World Health Organization's (WHO) Expert Committee on Drug Dependence (ECDD or Expert Committee) released in January 2019 the outcomes of the first-ever critical review of cannabis, recommending a series of changes in the current scheduling of cannabis-related substances under the UN drug control conventions.¹ Eagerly awaited, the ECDD recommendations contain some clearly positive points, such as acknowledging the medicinal usefulness of cannabis by removing it from Schedule IV of the 1961 Single Convention on Narcotics Drugs; clarifying that cannabidiol (CBD) is not under international control; and addressing some long-standing scheduling inconsistencies.

But the ECDD recommendations also reveal problematic underlying evaluation methods and scheduling procedures along with a very questionable rationale for keeping cannabis in Schedule I. Moreover, the

recommendations leave many questions unanswered regarding levels of control for different types of medical cannabis preparations. The potential repercussions of those more questionable aspects of the ECDD recommendations trigger legitimate concerns that merit a close examination by governments and by civil society.

These concerns are heightened precisely because the recommendations result from the first-ever WHO critical review of cannabis. Allowing the questionable aspects of the recommendations to escape scrutiny risks not only accepting dubious scheduling recommendations now, but also risks acquiescing to problematic underlying evaluation methods and procedures. Governments should seriously consider their options for challenging these aspects of the review, since their acceptance now could set a damaging precedent for the future.

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Considered in the wider context of the cannabis policy reforms now being debated and enacted in many countries around the world, it is clear that the entire ECDD review process has been tightly constrained by the original inclusion of cannabis in the 1961 UN Single Convention. That initial decision has straightjacketed UN-level deliberations on cannabis ever since, and has made it virtually impossible for processes such as the just-completed ECDD review to engage constructively with some of the fundamental questions policymakers are grappling with today.

Perhaps the clearest illustration of this disconnect can be found in the rationale provided by the ECDD for recommending that cannabis remain in Schedule I of the 1961 convention. As the basis for this conclusion, the ECDD cited *“high rates of public health problems arising from cannabis use and the global extent of such problems”*. As explained below, this rationale is evidently at odds with the evaluation standards that the Expert Committee should be using. At another level, citing the presence of public health problems associated with cannabis as the justification for keeping cannabis in Schedule I fails to consider whether public

health goals could be better achieved through different policy approaches.

If there are solid reasons to believe that public health problems associated with cannabis are not being prevented or contained by prohibitionist policies—and may even be exacerbated and amplified by them—then it would be appropriate to consider whether an alternative regulatory framework might offer a more effective option to minimize the harms that can be associated with cannabis use and to benefit society more broadly. In fact, this is the question now on the table in many countries, and citizens and policymakers in an increasing number of jurisdictions are persuaded that legal regulation does offer a better way. In the dynamic contemporary context, with some governments already enacting regimes to legally regulate cannabis for non-medical uses, the prohibitionist logic of the treaties continues to prevent UN structures—such as the WHO review process and the recent International Narcotics Control Board (INCB) report—from even engaging with some of the most relevant and consequential questions now on the policy agenda.

History of the WHO cannabis review

Cannabis first entered the international drug control system in 1925 and ended up in the strictest schedules I and IV of the UN 1961 Single Convention under conditions that would clearly be considered unacceptable by today’s scientific standards. In the 1950s the

predecessor of the ECDD took a strong position against cannabis, claiming that *“cannabis abuse comes definitely under the terms of its definition of addiction”* and *“is very likely to be a forerunner of addiction to opiates”* and that there should be *“extension*

of the effort towards the abolition of cannabis from all legitimate medical practice”.² The decisive reference document for the decision to place cannabis under such strict control was a 1955 paper in which the former secretary of the WHO Expert Committee concluded that “the present geographical extension of cannabism constitutes a medical and social danger of no small importance. The clients are mainly Mohammedans and coloured people, but there are already reports concerning Europeans smoking such cigarettes. From every point of view, this is an undesirable development. [...] It is important to realize that not only is marihuana smoking per se a danger, but that its use eventually leads the smoker to turn to intravenous heroin injections”.³

Still in 1968, the last time cannabis appeared on the ECDD agenda until the current review process began, the committee repeated its position that “medical need for cannabis as such no longer exists”, and “strongly reaffirms the opinions expressed in previous reports that cannabis is a drug of dependence, producing public health and social problems, and that its control must be continued”.⁴ At the same 1968 meeting it was recognised that more data were needed “to permit accurate assessment of the degree of hazard to public health”, and it was noted that important constituents of cannabis had recently been isolated, which would facilitate further research.⁵ The main psychoactive cannabinoid, THC, was subsequently placed in the strictest schedule of the 1971 Convention on Psychotropic Substances (and has gone through several reviews since then).⁶ Cannabis itself, however, had until

recently never been formally reviewed under the auspices of the UN system.⁷

Ironically, the origins of the current comprehensive review of cannabis-related substances can be found in a 2009 CND resolution tabled by Japan, originally entitled ‘Cannabis Seeds as a Global Threat’ and with the intention of extending international control to cannabis seeds.⁸ In the final adopted version, however, the CND “look[ed] forward to an updated report on cannabis by the Expert Committee”,⁹ which provided the ECDD with a mandate to decide at its 35th meeting in 2012 to include cannabis on the agenda of its next meeting, which was scheduled for June 2014 in Geneva. It is also noteworthy that in early 2014 the INCB included in its Annual Report an invitation to the WHO “to evaluate the potential medical utility of cannabis and the extent to which cannabis poses a risk to human health”.¹⁰

At the 36th meeting in 2014, however, the Expert Committee decided “because of the complexity of such a review” to first develop an *Information Document* to inform and discuss the modalities of such a review.¹¹ The Expert Committee’s Secretariat commissioned an additional paper to be discussed at the 37th meeting of the ECDD in 2015. While not a comprehensive literature review, *Update of Cannabis and its medical use* was supposed to provide a “summary of the current status of the field and a framework to incorporate new information as it arises”.¹² At that meeting the Expert Committee requested the Secretariat to ‘begin collecting data’ that would inform

pre-reviews for a range of substances, including the cannabis plant and cannabis resin.¹³ Finally, by its 38th meeting in 2016, the Expert Committee set the formal pre-review process in motion, with the Expert Committee recommending the convening of “*a specific meeting dedicated to cannabis and its component substances*”.¹⁴

Up to this point the ECDD had maintained the position that “*material to formally review the status of Cannabis as a scheduled substance is either insufficient or inconclusive. WHO will continue to review all available scientific evidence to determine whether the current scheduling status should change*”.¹⁵ A fast track was initiated for CBD, considered the least controversial among the cannabis-related substances, and based on a critical review the Expert Committee recommended at its 39th meeting in November 2017 not to bring CBD under international control. Eventually, the ‘specific meeting’ that had been called for in 2016 was held in June 2018, when it was decided to move forward with critical reviews of the cannabis plant, resin, extracts and THC.¹⁶ A follow-up meeting was then held in November 2018 to discuss outcomes and decide on recommendations for scheduling.

Meanwhile, the cannabis policy landscape around the world has been undergoing significant changes. Rapid expansion of the medical cannabis market has taken place across Europe (Czech Republic, Germany, Greece, Luxembourg, Poland, Slovenia and Switzerland) and Latin America (Argentina, Chile, Colombia, Mexico, Peru and Uruguay).

More recently this trend has also become visible in the Caribbean, Africa and Asia, in countries such as Jamaica, St. Vincent and the Grenadines, India, South Africa and Thailand.¹⁷ Moreover, in the Americas cannabis policy reforms started to move beyond medicinal uses and to break out of the confines of the UN drug control treaty regime. Beginning in 2012, ten U.S. states plus the District of Columbia have approved ballot initiatives or passed laws to regulate cannabis for adult use, and Uruguay (2013) and Canada (2018) have introduced legally regulated cannabis markets at a national level.

While it was clear from the beginning that the WHO was embarking on a politically very sensitive journey, these rapid policy changes multiplied the tensions and expectations. Medical use of cannabis had already become quite widely accepted, and the issue of regulating non-medical uses of cannabis had also appeared squarely on the table at the CND in Vienna. Canada’s decision to legally regulate its domestic non-medical cannabis market, accompanied by a candid acknowledgement that doing so entailed “*contravening certain obligations relating to cannabis under the three UN drug conventions*”,¹⁸ triggered aggressive responses from the Russian Federation (RF) and the INCB. In June 2018, shortly after the Canadian Parliament had approved Bill C-45, the INCB issued a press release asserting that Canada’s reform not only contravened the drug treaties but also their “*overarching objectives of safeguarding the health and welfare of people*” and that the Board was “*very concerned about the public*

health situation in Canada which will result from the Government's decision to legalize the non-medical use of cannabis".¹⁹ At the CND intersessional a few days later, Russia's ambassador referred to "dramatic developments in the international drug control policy related to the recent measures taken by the Canadian authorities" that will be "detrimental to the health and wellbeing of the humanity. [...] Ottawa has no right to make unilateral decisions, which are meant to impact the integrity of the international drug control conventions, and promote a selective approach to their implementation, thus opening the Pandora's box. If other countries choose to follow the path taken by Canada we will see the international legal drug control regime undergoing deep erosion and potentially being destroyed."²⁰

On 17 October 2018, the day Canada's new cannabis law came into effect, the RF issued a statement accusing the Canadian government of "consciously destroying the international drug control regime" and that "the logic of the selective execution of multilateral, legally binding documents by Ottawa is unacceptable, inherently hypocritical and runs counter to protecting the so-called 'rule-based world order', the concept of which is now actively promoted by some Western political forces". Close coordination apparently took place between the RF and

the INCB secretariat, as similar expressions appeared in an INCB press release that same day, which alleged that "by moving forward with the legalisation of cannabis for non-medical purposes in disregard of its legal obligations and diplomatic commitments, the Government of Canada has contributed to weakening the international legal drug control framework and undermining the rules-based international order."²¹

Diplomatic tensions had thus reached a boiling point by the time the ECDD met in mid-November 2018 to discuss the outcomes of the critical review process and to decide on scheduling recommendations. The rising tensions evidently made the committee err on the side of caution so as not to add fuel to the fire. That polarised atmosphere also explains why, at the last moment, the WHO presentation of the recommendations at the reconvened CND session in December 2018 was cancelled because WHO Director-General Tedros Adhanom Ghebreyesus had not yet cleared them for release. Expectations and anxieties were therefore sky-high when the WHO finally released the outcomes of the five-year review process and the recommendations for rescheduling at the end of January 2019 (see box).

The ECDD cannabis recommendations, issued January 2019

- **Recommendation 5.1:** The Committee recommended that Cannabis and Cannabis Resin be deleted from Schedule IV of the 1961 Single Convention on Narcotic Drugs.
- **Recommendation 5.2.1:** The Committee recommended that dronabinol and its stereoisomers (*delta*-9-tetrahydrocannabinol) be added to Schedule I of the 1961 Single Convention on Narcotic Drugs.
- **Recommendation 5.2.2:** The Committee recommended the deletion of dronabinol and its stereoisomers (*delta*-9-tetrahydrocannabinol) from the 1971 Convention on Psychotropic Substances, Schedule II, subject to the Commission's adoption of the recommendation to add dronabinol and its stereoisomers (*delta*-9-tetrahydrocannabinol) to Schedule I of the 1961 Single Convention on Narcotic Drugs.
- **Recommendation 5.3.1:** The Committee recommended that tetrahydrocannabinol (understood to refer to the six isomers currently listed in Schedule I of the 1971 Convention on Psychotropic Substances) be added to Schedule I of the 1961 Single Convention on Narcotic Drugs, subject to the Commission's adoption of the recommendation to add dronabinol (*delta*-9-tetrahydrocannabinol) to the 1961 Single Convention on Narcotic Drugs in Schedule I.
- **Recommendation 5.3.2:** The Committee recommended that tetrahydrocannabinol (understood to refer to the six isomers currently listed in Schedule I of the 1971 Convention on Psychotropic Substances) be deleted from the 1971 Convention on Psychotropic Substances, subject to the Commission's adoption of the recommendation to add tetrahydrocannabinol to Schedule I of the 1961 Single Convention on Narcotic Drugs.
- **Recommendation 5.4:** The Committee recommended deleting Extracts and Tinctures of Cannabis from Schedule I of the 1961 Single Convention on Narcotic Drugs.
- **Recommendation 5.5:** The Committee recommended that a footnote be added to Schedule I of the 1961 Single Convention on Narcotic Drugs to read: "Preparations containing predominantly cannabidiol and not more than 0.2 percent of *delta*-9-tetrahydrocannabinol are not under international control."
- **Recommendation 5.6:** The Committee recommended that preparations containing *delta*-9-tetrahydrocannabinol (dronabinol), produced either by chemical synthesis or as a preparation of cannabis, that are compounded as pharmaceutical preparations with one or more other ingredients and in such a way that *delta*-9-tetrahydrocannabinol (dronabinol) cannot be recovered by readily available means or in a yield which would constitute a risk to public health, be added to Schedule III of the 1961 Convention on Narcotic Drugs.

Recognition of medical use: a positive if obvious step

ECDD's recommendation 5.1 to delete cannabis from Schedule IV is at once positive and obvious. *"The evidence presented to the Committee did not indicate that cannabis plant and cannabis resin were particularly liable to produce ill-effects similar to the effects of the other substances in Schedule IV"* and given the now widespread acceptance of medicinal use by many Member States, the ECDD could not have reasonably advised otherwise. The deletion from Schedule IV is relevant, as it fully acknowledges medical usefulness and removes cannabis from the purview of the treaty provision that calls on Parties to consider prohibiting cannabis including for medical purposes.

As positive as this ECDD recommendation is, it is hard to imagine how the Expert Committee could have arrived at any other conclusion without raising serious questions about the ECDD's credibility and independence. Given the ECDD's active opposition since its earliest days to any medical use of cannabis, the recommendation now to delete cannabis from Schedule IV represents a long-overdue correction of an historical error and

injustice. The WHO and its expert committee bear significant responsibility for the decades of negative consequences due to this injustice.

At the same time, the significance of removing cannabis from Schedule IV should not be overstated, as the recommended imposition of full prohibition even for medical purposes has always been optional. A Party to the Convention is only required to follow the recommendation *"if in its opinion the prevailing conditions in its country render it the most appropriate means of protecting the public health and welfare"*.²² In other words, if a Party was of the opinion that this was not the most appropriate way, it could still decide to permit the cultivation and use of cannabis medical purposes, as many countries indeed have done in spite of its Schedule-I status. Nevertheless, it is important that governments now support the recommendation to delete cannabis from Schedule IV, not least because in a number of countries there is an immediate and direct connection between international schedules and national legislation.

Cannabis remains in Schedule I

*The Committee then considered whether cannabis and cannabis resin were better placed in Schedule I or Schedule II of the 1961 Single Convention on Narcotic Drugs. While the Committee did not consider that cannabis is associated with the same level of risk to health of most of the other drugs that have been placed in Schedule I, it noted the high rates of public health problems arising from cannabis use and the global extent of such problems and for these reasons recommended that cannabis and cannabis resin continue to be included in Schedule I of the 1961 Single Convention on Narcotic Drugs.*²³

The ECDD's apparent rationale to recommend keeping cannabis in Schedule I is highly questionable on procedural grounds. The Single Convention establishes that the first test the WHO must do in its review process is whether a substance is *"liable to similar abuse and productive of similar ill effects as the drugs in Schedule I or Schedule II"* or is 'convertible' into one of those drugs (Article 3, paragraph 3-iii). This 'similarity principle', which the Expert Committee does use to argue for the removal of cannabis from Schedule IV, is the basic threshold test for recommending whether cannabis should be placed in Schedule I (e.g., on a par with morphine and cocaine) or II (e.g., on a par with codeine). According to the Commentary, *"Substances which are comparatively less dangerous and widely used in medical practice may therefore often be proposed for inclusion in Schedule II"*.²⁴

The Committee found that cannabis is not associated with the same level of risk to health of most of the other drugs in Schedule I, but then argued that because of *"the high rates of public health problems arising from cannabis use and the global extent of such problems"*, cannabis should nevertheless remain in Schedule I. The review does mention *"a number of adverse effects associated with long term cannabis use"* and that cannabis *"can cause physical dependence in people who use the drug daily or near daily"*,²⁵ but it is hard to see how the recommendation to keep cannabis in Schedule I can be reconciled with the ECDD's view that it is not associated with

the same level of risk of most other drugs placed in Schedule I.

'High rates' or the 'global extent' of cannabis-related health problems are not a sufficient criterion for the similarity principle. As the Critical Review report on Cannabis and Cannabis Resin says: *"In terms of harm, most harm is caused by frequent or heavy use, especially heavy use over time [...] Thus, prevalence of use per se is not a good indicator of public health harm"* (Section 5: Epidemiology, p. 40). The similarity test requires evaluating whether cannabis is *"liable to similar abuse and productive of similar ill effects"* as drugs in Schedule I or Schedule II.²⁶ In the event that insufficient similarity is found with substances in either of those schedules, there is no justification for international control and the recommendation should be to not add the substance under review to any of the schedules, or—in this case—to delete it from the schedules they are currently in. With its recommendation to keep cannabis in Schedule I, the ECDD seems to have failed to apply the required similarity test, and the consequences of letting that pass unchallenged could be quite severe.

As the ECDD recognises, *"cannabis has never been subject to a formal pre-review or critical review"*.²⁷ As mentioned above, the current placement of cannabis in Schedules I and IV was not based on a proper WHO review, but rather on scientifically dubious arguments pushed by a few individuals in the 1950s.²⁸ As a consequence, the validity of its scheduling status has always been questionable. If this whole set of new ECDD

recommendations were to be approved, the continuation of cannabis in Schedule I will be more difficult to challenge since it would now, for the first time, be based on a WHO critical review of the latest scientific evidence. Moreover, and crucially, keeping cannabis in Schedule I is also the basis for the subsequent ECDD recommendations to add THC/dronabinol to Schedule I as well, with potential repercussions for a wide variety of medical cannabis preparations. In this regard, it is also important to note that

an ECDD recommendation to maintain the *status quo* (that is, to keep a substance in its current schedule) does not entail a vote by the CND. In view of the precedent-setting nature of this review and the fact that the recommendation to maintain cannabis in Schedule I does not trigger voting, concerned Member States should ensure that the necessary steps are now taken to closely scrutinize ECDD's rationale.

Moving THC from the 1971 to the 1961 Convention

There are good reasons for trying to resolve the inconsistency that cannabis, resin and extracts are currently scheduled under the 1961 Convention as 'narcotic drugs', while *delta*-9-THC and its (stereo)isomers are scheduled under the 1971 Convention as 'psychotropic substances'. Transferring the psychoactive cannabinoids from the 1971 to the 1961 schedules, as proposed in **recommendations 5.2.1, 5.2.2, 5.3.1 and 5.3.2**, therefore in principle improves the coherence of the scheduling system. However, after the questionable conclusion that cannabis itself should remain in Schedule I, the ECDD then does apply the similarity principle to dronabinol/THC: "*As Δ 9-THC is liable to similar abuse as cannabis and has similar ill-effects, it meets the criteria for inclusion in Schedule I of the 1961 Single Convention on Narcotic Drugs*".

This recommendation seems to be at odds with previous recommendations the ECDD has made on dronabinol/THC. On the basis of previous critical reviews of dronabinol,

the ECDD recommended to reschedule it initially from the 1971 Convention's Schedule I to the less stringent Schedule II, which was adopted by vote in 1991. Ten years later, the Committee concluded that "*the very low rate of actual abuse of Δ 9-THC suggest that the risk to public health may actually be less than required for substances to be included in Schedule II*",²⁹ but the recommendation to reschedule it further down to Schedule IV (the least strict schedule under the 1971 Convention) was considered so controversial that then UNODC Executive Director Antonio Maria Costa intervened, preventing the recommendation from ever reaching the CND.³⁰ In 2006, the ECDD then advised to move dronabinol/THC to Schedule III, which the CND initially refused to consider and which was finally, in 2014, rejected by vote.³¹

Thus, all previous reviews of dronabinol led the ECDD to recommend a transfer to a less strict schedule, whereas now the

recommendation to add it to Schedule I of the Single Convention means placing it under stricter control compared to its current placement (in Schedule II of the 1971 Convention). And that recommendation on the part of the ECDD is not based on any new insights about greater harmfulness, but purely on the basis of the similarity principle compared with cannabis itself. There is a certain circularity in that argumentation, as the similarity test has not

been applied to cannabis itself compared to other drugs in Schedule I.

Medical preparations containing THC, except the Sativex and Marinol-type preparations recommended for Schedule III (see below), in principle will have to be treated with the same strict controls as preparations containing morphine and cocaine, and do not fall under the lighter regime applicable to preparations containing codeine, for example.

Extracts and ‘pharmaceutical preparations’

Persisting legal uncertainties surrounding CBD would be resolved to a certain extent if **recommendations 5.4 and 5.5** are approved. The proposed deletion of the category of ‘extracts and tinctures’ and the proposed added footnote would make crystal clear that CBD preparations (containing <0.2% THC) are not under international control. This is positive, though one may question the choice for the quantity threshold of 0.2% THC. For example, whole-plant CBD extracts from hemp can easily contain more than 0.2% THC, and the 0.2% threshold might cause problems for those countries that already use other thresholds in their domestic legislation.

Recommendation 5.6 usefully clarifies that ‘dronabinol’ simply refers to *delta-9-THC* whether it is produced synthetically or extracted from the cannabis plant, because sometimes the argument has been used that dronabinol only refers to the chemically synthesized form of THC. However, the

definition of ‘preparations’ used here to define those preparations that could be exempted from several controls by adding them to Schedule III, raises further questions. The ECDD, in their argument to delete the category of ‘extracts and tinctures’, refers to the fact that ‘preparations’ (defined as mixtures containing a scheduled substance), on the basis of treaty article 2.3, “*are subject to the same measures of control as the drugs which they contain*”, except for specific exemptions made for preparations under Schedule III.

The ECDD then recommends exempting under Schedule III preparations “*compounded as pharmaceutical preparations with one or more other ingredients and in such a way that delta-9-tetrahydrocannabinol (dronabinol) cannot be recovered by readily available means or in a yield which would constitute a risk to public health*”. No further clarification is provided about the criteria for easy recoverability, about the definition of ‘compounded as pharmaceutical

preparations’, and how to distinguish those exemptions from the mixtures containing dronabinol/THC that would fall under Schedule I. It appears that on this point, the recommendations attempt to introduce a somewhat arbitrary distinction between products like Sativex and Marinol (which are specifically mentioned as examples) and other types of medicinal preparations based on cannabis extracts. The definition used for the exempted preparations, however, could also apply to many other mixed preparations with cannabis extracts for medical purposes.

The intention to loosen controls on medicinal cannabis products and make them more easily available through an exemption in Schedule III is certainly positive, but it must

be made clear that the broad description ‘compounded as pharmaceutical preparations’ cannot be narrowly construed to mean ‘preparations like Sativex and Marinol produced by the pharmaceutical industry’. The vaguely-defined category of exempted preparations seems intended to provide a limited number of very specific products patented by pharmaceutical companies with preferential treatment over a wide array of more natural cannabis extracts with similar medicinal properties. At the same time, perhaps, the vagueness of the definition may give some discretion to countries to decide for themselves which preparations would be eligible for a lighter control regime.

The International Narcotics Control Board (INCB) and “medical cannabis”

Some of the WHO recommendations appear to echo highly problematic positions on medical cannabis taken by the INCB. At the June 2018 ECDD cannabis meeting, the two INCB representatives present (Galina Korchagina, INCB Member from the Russian Federation, and Rossen Popov, Deputy Secretary of the INCB secretariat) advised the Expert Committee “*that when considering the possibility of using cannabis derivatives for the treatment of certain health conditions, it is most appropriate to avoid the notion of ‘medical cannabis’.* This is intended to ensure that when reference is made to medicinal products, it is understood to refer to products that have been appropriately tested, have passed a full scientific evaluation including clinical trials and are licensed as medicines.”³²

The INCB Annual Report for 2018, released on 5 March 2019, devotes its thematic chapter to “*Cannabis and cannabinoids for medical, scientific and ‘recreational’ use: risks and benefits*”.³³ Throughout the chapter, the Board puts “medical cannabis” and “medical use” in quotation marks whenever it refers to the cannabis plant to indicate that—according to its treaty interpretation—only the medical use of cannabinoids in pharmaceutical preparations constitutes legitimate medical use. “*Under the Convention, cannabinoids may be evaluated in controlled clinical trials to assess the benefits and harms of their use in medicine*”,³⁴ according to the INCB, but “[a]ttempts to market and promote the medical use of cannabis products as ‘herbal medicines’ are inconsistent with the classification of cannabis

and its derivatives under the 1961 and 1971 conventions. *Pharmaceutical-quality cannabinoids should be approved for clearly defined medical uses by the country's pharmaceutical regulatory system.*"³⁵ The Board also restates its position, without any legal substantiation, *"that personal cultivation of cannabis for medical purposes is inconsistent with the 1961 Convention as amended because, inter alia, it heightens the risk of diversion"*.³⁶

The INCB's principal message seems to be that *"the medical use of cannabinoids is allowed under the international drug control treaties"* only under strict conditions,³⁷ and that *"medical cannabis"* programmes have *"been used by advocates of cannabis legalization to promote the legalization of non-medical cannabis use"* and *"to create a de facto legal cannabis market for non-medical users"*.³⁸ Without denying the fact that medical cannabis regimes in some U.S. states have certainly blurred the legal line between medical and recreational uses, and that control of quality standards is essential for any type of medicine, the distinction the INCB tries to make between pharmaceutical cannabinoids and cannabis plant materials has no discernible basis in the drug conventions whatsoever.

In fact, the WHO critical review on cannabis and cannabis resin refers to various medical cannabis programmes where natural cannabis products have been fully authorized, stating that by November 2017, *"medical cannabis can be used legally in Australia, Canada, Chile, Colombia, Germany, Israel, Jamaica, The Netherlands, Peru, and in*

29 US states".³⁹ The review report also cites many studies that have shown the therapeutic usefulness of plant materials. There is not a single reference in the drug conventions, the commentaries or the conference proceedings that sustains the INCB claim that only pharmaceutical preparations of cannabinoids can qualify as legitimate medical use. To the contrary, the 1961 commentary says: *"The term 'medical purposes' does not necessarily have exactly the same meaning at all times and under all circumstances. Its interpretation must depend on the stage of medical science at the particular time in question; and not only modern medicine, sometimes also referred to as 'western medicine', but also legitimate systems of indigenous medicine such as those which exist in China, India and Pakistan, may be taken into account in this connexion."*⁴⁰

In a recent letter sent to a number of governments, the INCB also claims that the Single Convention requires limiting the cultivation of the cannabis plant strictly to medical and scientific purposes (under the general obligations of Article 4) and the specifically mentioned exemptions of *"industrial (fibre and seeds) or horticultural purposes"* (Article 28, *Control of Cannabis*, paragraph 2). According to the INCB, the cultivation of cannabis plants for any other purpose other than those explicitly indicated (medical, scientific, fibre, seeds and horticultural) cannot be considered licit under the treaty provisions. The cultivation of cannabis or hemp for the purpose of CBD extraction (even though CBD is not under international control) could only be considered licit if it is destined for clearly

defined and approved medical purposes, not for any food supplements, beverages or smokable products. The INCB seems to mistakenly conflate the treaty restrictions on “the cultivation of the cannabis plant for the production of cannabis [defined as the flowering and fruiting tops] and cannabis resin” (article 28, paragraph 1) with cultivation of the cannabis plant in general.

Conclusions

The WHO cannabis recommendations released in January 2019 had been eagerly awaited for good reason. Although cannabis was placed in the strictest control schedules of the 1961 UN Single Convention on Narcotic Drugs, until now cannabis had never been the subject of a critical review by the WHO’s Expert Committee on Drug Dependence.

The ECDD’s recommendations include some clearly positive points, especially acknowledging the medicinal usefulness of cannabis by removing it from Schedule IV of the 1961 Single Convention and clarifying that CBD is not under international control. Moreover, the documents generated by the Expert Committee in the course of its unprecedented review process provide a wealth of up-to-date information based on a thorough review of the available scientific evidence, and will surely be an authoritative reference for years to come on all aspects of medicinal uses of the various cannabis-related substances, including the plant materials.⁴²

As the 1961 Commentary about the special provisions on cannabis cultivation (in Articles 23 and 28) spells out, however, “*this régime applies only to the cultivation of the cannabis plant for the production of cannabis and cannabis resin. Cultivation of the plant for any other purpose, and not only for the purposes mentioned in paragraph 2, is consequently exempted from the control régime*”.⁴¹

However, notwithstanding the scientific evidence marshalled over the course of the review process, the ECDD recommendations also reveal problematic underlying evaluation methods and scheduling procedures, along with a very questionable rationale for keeping cannabis in Schedule I. The potential repercussions of those more questionable aspects of the ECDD recommendations trigger legitimate concerns that merit a close examination by governments and by civil society. Precisely because the recommendations result from the first-ever WHO critical review of cannabis, they will set an important precedent. Governments should seriously consider their options for challenging the problematic aspects of the review, since their acceptance now could set a damaging precedent for the future.

The recent-completed ECDD review also highlights how the initial decision to include cannabis in the UN drug treaties continues to straightjacket UN-level deliberations on cannabis policy. The drug treaties’ confines make it nearly impossible for UN structures to constructively engage with some of the

fundamental questions being considered by policymakers in many countries around the world today, such as whether and how to regulate *non-medical* cannabis—a policy that is beyond the bounds of what the drug treaties allow, but is nevertheless being considered and enacted in a growing number of countries.

The limitations of the ECDD review also highlight that even far greater progress in bringing the UN drug treaties' cannabis scheduling in line with modern science will be unlikely to clear the path for legal regulation of non-medical cannabis. Since such an approach remains outside what the drug control treaties permit, countries wishing to regulate cannabis for non-medical use in a way that comports with international law will need to find a different pathway out of the treaty strictures. Among the treaty reform options not requiring consensus, the procedure of *inter se* modification, provided for by the Vienna Convention on the Law of Treaties, appears to offer the most elegant approach.⁴³ *Inter se* modification would require a group of two or more the like-minded governments to conclude a new agreement with a clear commitment to the original treaty aim to promote the health and welfare of humankind and to the original treaty

obligations vis-à-vis countries not party to the new agreement. A legally-grounded and coordinated collective response has many clear benefits compared to a chaotic scenario of a growing number of different unilateral reservations and questionable re-interpretations. Among other things, *inter se* modification would provide opportunities to experiment and learn from different models of regulation as well as open the possibility of international trade enabling small cannabis farmers in traditional Southern producing countries to supply the emerging regulated licit spaces in the global market.

Numerous governments have already insisted on the need for more time to examine the WHO recommendations before they are put to a vote. Voting will be postponed until the reconvened CND session in December 2019, or the next regular CND session in March 2020. Governments clearly do need more time to provide the necessary scrutiny to this unprecedented ECDD review process and the recommendations that emerged. Rather than just delaying a difficult decision out of political convenience, the months ahead should be used for an honest and evidence-based discussion among Member States, civil society, academia and the relevant UN entities.

ENDNOTES

¹ World Health Organization, *Annex 1 - Extract from the Report of the 41st Expert Committee on Drug Dependence: Cannabis and cannabis-related substances*, 5. Cannabis and cannabis-related substances, January 2019. https://www.who.int/medicines/access/controlled-substances/Annex_1_41_ECDD_recommendations_cannabis_22Jan19.pdf

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ABOUT THE CONTRIBUTING ORGANIZATIONS



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