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International Drug Policy Consortium

IDPC RESPONSE TO THE INCB ANNUAL REPORT FOR 2017

AUGUST 2018

Executive summary

Key points

- In the approach to the 2019 Ministerial Segment and its review of international drug control, the INCB's Annual Report for 2017 is arguably of special importance. The INCB has chosen to stress the core importance of human rights and public health principles in the implementation of drug control. However, the Board's conception of human rights within drug control, at times, remains arguably narrow; for example, there is no comment on the human rights impact of crop eradication and drug-policy related violence.
- The Board's analysis, as represented here, has shifted to take into account the complexity of contemporary drug markets and of the differing views on the merits and otherwise of international drug policies. To some extent at least, there is a recognition of the validity of divergent visions of drug control, as opposed to a 'black and white' understanding of these positions.
- The thematic chapter in this year's report is concerned with drug dependence treatment. It notes that the 2016 UNGASS Outcome Document states that dependence can be treated 'through evidence-based and voluntary treatment programmes'. The chapter, much of which is strongly positive, defines treatment as a human right, referring to the body of human rights legislation that defends it as such.
- This report maintains the Board's position on regulated markets for cannabis such as those in Uruguay, various US states and Canada. It is perhaps restricted to this position by the terms of its mandate, as the compliance-body of the international drug control conventions. However, the INCB at times comes perilously close to inappropriately influencing the international debate. Moreover, the INCB's role would be more helpful were it to utilise its expertise to identify ways to resolve the growing tensions over cannabis rather than simply reiterating that the conventions 'just say no'.
- In accord with its recent strategy, the INCB uses the report to argue for the equitable access and availability to controlled medicines. The report includes an increased focus on the medicinal uses of cannabis, noting that several states have taken the regulatory steps necessary to provide cannabis and its derivatives for medical purposes. In this context, however, the Board highlights the place of cannabis in schedules I and IV of the 1961 Single Convention, a scheduling that supposedly reflects the dangerous properties of the substance. Again, the INCB walks a fine line here, as it has no role in determining the state of scientific evidence regarding medical cannabis.
- The report also adopts a more robust stance regarding the public health utility of drug consumption rooms. A subtle hardening of its position is visible, with a return to the language of 'drug abuse' and an emphasis on the dangers of condoning and encouraging drug use, particularly when it is obtained from illicit sources. This is a backward movement when compared with the 2016 report.

Introduction

As we approach the Ministerial Segment of the 62nd session of the Commission on Narcotic Drugs (CND) and the decennial review of the achievements of the United Nations (UN) drug control regime against the goals set by the 2009 Political Declaration and Action Plan, the international community of states remains divided and arguably increasingly polarised in their positions on how to address the 'world drug problem'. Having struggled to achieve the necessary consensus for the Outcome Document of the UN General Assembly Special Session (UNGASS) on the World Drug Problem in April 2016, fundamental differences in perspective can be seen around a range of issues, human rights and regulated cannabis markets key among them. Stakeholders, member states, international agencies and civil society alike, seem to be approaching March 2019 with a combination of curiosity and trepidation as they seek to influence the output of the Segment where they can; a document that, while still uncertain in terms of its form,[1] is after all intended to play a key role in shaping the international response to the drug issue for the next decade or so.

Within this context, and as the penultimate Annual Report to be published before 1 March 2019, the Annual Report of the International Narcotics Control Board for 2017 is important for not only what it provides in terms of information on markets and recent policy developments, but also in relation to the overarching tone, focus and approach adopted. These latter points are of significance since, as is possible to identify at CND sessions over the years, the Annual Report does much to influence the direction and focus of international discussion and debate. Including data up until 1 November 2017, the Board must once again be commended on the Report's scope, scale of information collection, synthesis and structure. In line with its mandate under the Single Convention on Narcotic Drugs, it contains a great detail of informative material on the state and functioning of the international drug control system; a multilateral framework built upon a suite of three UN drug control conventions and constructed with the aim of managing the global market for a range of substances for medical and scientific purposes while simultaneously supressing – with the aim of ultimately eliminating – the illicit market for those substances. The Report is useful in what it tells us in a predominantly regional format about markets in plant-based drugs, synthetics and New Psychoactive Substances (NPS), as well as the illicit use of prescription drugs and associated policy responses over the previous year. Of note this year is the Report's coverage of the situation within Afghanistan and the opioid crisis in North America. It is also interesting to see some attention devoted to illegal 'internet pharmacies'. Additionally, as has been the case in previous years and as is mentioned at several points in the pages that follow, the Report is particularly useful in offering an overview of the global situation regarding production, and critically mindful of the inequity of the situation regarding access to internationally controlled substances for medical and scientific purposes. On this issue and others, it is edifying regarding the progress of states' action relative to CND resolutions, commitments agreed within the Outcome Document and policy developments in those states recently visited by an INCB mission.

More broadly, however, the Report also tells us a great deal about the current views of the Board, the watchdog of the drug control conventions (see Box 1), in the face of an increasingly fluid and complex

Box 1 The INCB: Role and composition

The INCB is the 'independent, quasi-judicial expert body'[2] that monitors the implementation of the 1961 Single Convention on Narcotic Drugs (as amended by the 1972 Protocol), the 1971 Convention on Psychotropic Substances and the precursor control regime under the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. The Board was created under the Single Convention and became operational in 1968. It is theoretically independent of governments, as well as of the UN, with its 13 individual members serving in their personal capacities. The World Health Organisation (WHO) nominates a list of candidates from which three members of the INCB are chosen, with the remaining 10 selected from a list proposed by member states. They are elected by the Economic and Social Council and can call upon the expert advice of the WHO. In addition to producing a stream of correspondence and detailed technical assessments arising from its country visits (all of which, like the minutes of INCB meetings, are never made publicly available), the INCB produces an annual report summarising its activities and views.

global drug market and an ever-wider range of national policies designed in response. This is particularly important considering the confluence of a polarisation of views among some member states and the forthcoming Ministerial Segment mentioned above. Consequently, it is good to see the Board maintain a generally positive position on human rights, including in relation to use of the death penalty for drug-related offences and regarding extrajudicial measures. Further, ongoing attention to the related issue of public health, including within the thematic chapter, is welcome, although as will be discussed there remains what might be seen as an ongoing reticence towards the harm reduction approach. The Board's views on cannabis are also telling regarding both therapeutic use and regulated markets for recreational consumption, a policy option that exceeds the current limits of the UN treaty system.

With the intention of exploring these and other issues, this response to the INCB Annual Report for 2017 is organised under five headings; each of which unsurprisingly contain a degree of overlap and interconnectivity. Approaching the Report from front to back to begin with, discussion starts with an analysis of the INCB President's Foreword before moving on to the thematic chapter I, 'Treatment, rehabilitation and social reintegration for drug use disorders: essential components of drug demand reduction'. The response itself then takes on more of a thematic approach to examine the Board's position on human rights and then public health before finishing with a discussion of cannabis.

Foreword to the Report: Recognising complexity

'Each year, the complexity of the world drug situation increases'. So begins the INCB President Viroj Sumyai's Foreword to the Annual Report for 2017. This statement is, on the surface, a familiar and relatively obvious one. Nonetheless, its place in initiating the Board's Report is significant. The complexity facing all those seeking to analyse and intervene positively in the global drug situation is a core element of this context. The previous scenario in which reformers stood on one side in clear opposition to the orthodoxy, with its Jurassic imagination on the other, is fast becoming a thing of the past, or has at least been radically reconfigured over the last decade. There is now every indication that the INCB – once at the very heart of prohibitive attitudes – has recognised that there are many discourses and practices that reach across the divide between conservatism and reform.

Central to these is the concept of human rights, of which the President observes in the Foreword: 'In commemorating the seventieth anniversary of the Universal Declaration of Human Rights, the INCB recalls that human rights are at the foundation of the mission and work of the United Nations' (p. iii). The Board notes the 'milestone anniversaries' of several key human rights instruments, and that these have prompted the INCB to give a specific focus on human rights in this year's Annual Report.

The Foreword consequently draws attention to Article 25 of the Universal Declaration, which sets out the right to health as a component of the right to an adequate standard of living. Accordingly, this year's Annual Report chooses for its thematic chapter the treatment, rehabilitation and social reintegration of those with 'drug use disorders'. President Sumyai also mentions the Outcome Document of the 2016 UNGASS, which characterises drug treatment as 'among the key operational objectives of its recommendations'.[3] The emphasis of the thematic chapter on human rights is interwoven with health and the right to health; it raises complexity in a wide number of ways, which will be explored in our discussion of the chapter and elsewhere.

Much of the remainder of the Foreword sets out the contents of the Annual Report. These include discussion of the therapeutic use of cannabinoids and the problems surrounding the lack of access to medicines, to which the Board refers as the 'global pain divide'. The underuse of opioids is discussed alongside the 'overdose epidemic in North America'. This contrasting situation is referred to by the Board as a binary opposition; it is representative of the double-edged sword of the opium poppy and its fruits. It is encouraging to see the INCB acknowledge the value of opioids; it states that 'opioids are not to be feared if administered and monitored properly' and calls for the provision of training for medical staff and for 'rational' prescribing practices – a position that is reinforced at various points throughout the publication.

The Foreword goes on to mention the Afghanistan Opium Survey of 2017, which reports that poppy cultivation has reached a record high.[4] Likewise, it points to the record levels of coca bush cultivation in Colombia and directs states to INCB resources including tools and initiatives in their attempt to suppress the illicit drug traffic. In the closing passages

of the Foreword, the President declares: 'We aim to continue expanding our analysis and support capacities to assist Governments around the world'. He continues: 'Drug policies must follow an approach that seeks to promote the health and welfare of humankind. The three international drug control conventions provide ample scope for the international community to provide this objective'.

This last statement is, in fact, arguable. The modern appetite for drugs, which has expanded since the 18th century and continues to do so, has shown little sign of reducing in the face of mechanisms of suppression.[5] The international drug control conventions, while they include an enabling element that seeks to provide medicines for those in need and are becoming increasingly linked with human rights and public health, still entail a powerful prohibitive element aimed at restricting all drug use to the medicinal, and interdicting the use of drugs for pleasure and entertainment. It is in this latter context that the problem and its solution lies, a tension that, as in previous years, permeates the entire publication.

Thematic chapter: Capturing the complexity of treatment

This year, the Report includes a thematic chapter on drug dependence treatment. It commences by claiming that the cornerstone of the drug control apparatus lies in concern for the health and welfare of humankind. Each of the three conventions, we are told, refer to this concern, mandating signatories to provide treatment, rehabilitation and social reintegration services for those people affected by problematic drug use (Para. 1). The chapter continues by stating that the 'treatment of drug use disorders, rehabilitation and social reintegration are among the key operational objectives given in the recommendations on drug demand reduction contained in the outcome document of the thirtieth special session of the General Assembly' (Para. 2). The Board notes that in the 2016 UNGASS outcome document, drug dependence is recognised as a 'complex health disorder characterised by a chronic and relapsing nature that can be treated through evidence-based and voluntary treatment programmes'.[6]

Drugs and human cultures

The Board acknowledges that human cultures have made use of psychoactive substances for millennia. However, it states that for certain substances and in specific contexts, consumption can assume pathological patterns that require intervention. 'Throughout the history of human civilization', claims the Board, 'societies have displayed varying levels of tolerance and permissiveness towards, and control over, the use of psychoactive substances' (Para. 3). Some of these substances, such as tobacco and alcohol, have been regulated, while others have been viewed as dangerous and made the objects of strict controls; 'This is the case for narcotic drugs and psychotropic substances controlled under the international drug control conventions' (Para. 3). The Board then states that, regardless of social attitudes and levels of control, there is a propensity for 'drugs' (so-called for the sake of brevity) to lead to 'disorders' associated with their use, whether this use is frequent or occasional. These disorders are linked with significant levels of disease or disability, with a drain on national resources, and with human suffering. The WHO is quoted to the effect that drug dependence accounts for some 0.9% of the global burden of disease, with opioid dependence constituting the majority of this sum (Para. 4).

This leads us back to the issue of complexity raised in the Foreword. The concept of drug dependence as a form of pathology dates back to the nineteenth century, becoming established within medicine in the last quarter of the century.[7] Prior to this, it was not considered as a criminal issue, but rather as an individual characteristic with little in the way of moral judgement attached. The characterisation of dependence as a medical condition is widely viewed as a progressive one, and an advance over the understanding of the 'drug addict' as a criminal. The medical conception has often resulted in people who are dependent on drugs being treated with compassion and as subjects of human rights. On the other hand, at its worst the concept has resulted in invasive and involuntary methods of 'cure', or the incarceration of individuals in compulsory drug detention centres.[8] In this latter context, it makes little difference whether the incarceration comes under the rubric of criminal justice or medicine. To judge the quality of a medical intervention and its impact on people who are drug dependent, it is necessary to examine the specific context of treatment.

Treatment in the Russian Federation

In the Russian Federation, for example, treatment often consists of confinement in a 'quarantine room' with other people undergoing the symptoms

of opioid withdrawal, sometimes handcuffed to a bunk bed, with no opioid substitution therapy.[9] The Andrey Rylkov Foundation for Health and Social Justice, an NGO which provides free sterile injecting equipment, describes the government drug policy thus: 'The public attitude is very hostile, and the government doesn't want to seem too humane towards drug users'. The government's primary strategy for dealing with people struggling with drug dependence is 'making them feel miserable', comments Anya Sarang, Director of the Andrey Rylkov Foundation, 'As if the social pressure will make them stop using drugs'.[10]

There is considerable evidence in support of Sarang. At the 61st session of the Commission on Narcotic Drugs (CND), Resolution 61/11 'Promoting non-stigmatizing attitudes to ensure the availability, access and delivery of health, care and social services for drug users', submitted by Canada and Uruguay, was the object of profound hostility from the delegation of the Russian Federation. Russia left the Committee of the Whole while the resolution was discussed, claiming that there is no stigmatisation within its borders. Russia's approach to drug dependence, which includes the prohibition of methadone, is justified by what it regards as a social and medical discourse.[11] It is consequently positive to see the INCB argue against the range of attitudes represented by the Russian Federation. In direct counterpoint to Russia, the Board comments that: 'Respecting the right of people affected by drug use disorders to health and treatment services will contribute to reducing the stigma and discrimination associated with those disorders' (Para. 6e).

The complexity of treatment and demand reduction measures

The next section discusses treatment, rehabilitation and social reintegration as essential components of demand reduction. It makes several points in this regard, including that people using drugs in a problematic way can resort to criminal activities in order to fund their consumption and that treatment reduces the impact of 'peer pressure' to use drugs. It reminds states that they are obliged by the conventions to provide treatment services to those in need of them. Both article 38 of the 1961 Single Convention and article 20 of the 1971 Psychotropic Convention require governments to take all possible measures to offer treatment, rehabilitation and social reintegration to people affected by drug dependence.

It also notes that research shows consistently that treatment saves governments money. Despite this, there is a global gap between the requirement for treatment and its provision. The INCB quotes the UN Office on Drugs and Crime (UNODC) to the effect that only 1 out of 6 treatment places for people in need are available for drug and alcohol treatment. In Latin America, the figure is 1 out of 11, and in Africa 1 out of 18. This demonstrates that the treatment gap is much greater in low and middle include countries.

The chapter includes a representational image of patterns of drug use, acknowledging in the process a level of the complexity that permeates drug consumption. The data for this pyramid states that: 95% of people do not use drugs; 5% use drugs with no pathological pattern; and 0.5% have 'drug use disorders' (Para. 10). It goes on to say that such 'disorders' are best viewed as bio-psycho-social in origin. The biological element is claimed to originate in neurological and biological dysfunctions. The social factors include social, economic, cultural and legal circumstances, and finally the psychological factors, such as the use of drugs to self-medicate in the face of stress. In addition, some drugs are more prone to producing dependence than others. It points out the controversy surrounding the extent to which drug use is a chosen activity or a compulsion. It is encouraging to see that the INCB does not attach overriding causal weight to the biological elements in its model, which leaves no room for human choice or autonomy.[12]

The trajectory of recovery is also considered by the thematic chapter. Here, however, the argument becomes at times highly deterministic in its use of the disease-model. The Board put forward the view that 'Once developed, drug use disorders run their course like other chronic, non-communicable diseases such as diabetes or hypertension'. It goes on to note that 'The treatment for all such chronic, non-communicable diseases, share certain characteristics: (a) treatment reduces the symptoms, without necessarily removing the root cause of disease; (b) adopting changes in behaviour and lifestyle is an important part of the treatment; and (c) relapses are common, in spite of treatment.

This deterministic vision is questionable. It is important to recall that the disease-model of drug dependence is based on an extended metaphor rather than a fixed ontological condition. As research reveals, consequently, some individuals can simply stop their use of drugs, while others may continue

on a permanent basis; some may have chaotic lifestyles while others remain stable and productive despite their drug use.[13] Indeed, the Board itself demonstrates this analysis. Many people who are formerly drug dependent, it claims, find it difficult to regain their place in society owing to the stigma associated with dependence and even with ex-dependence. This is rarely the case with ordinary diseases, except with regard to certain sexually transmitted diseases, which carry an equivalent moral cargo to that borne by drug dependence.

The INCB is on surer ground and takes into account complexity when it states that 'the outcome of treatment for drug dependence should not be defined only in binary terms of continued use versus complete abstinence'. Some individuals, the INCB observes, are able to reduce the harms of continuing drug dependence – as noted in the previous paragraph. This awareness of flexibility is a distinct improvement from the Board's former position, as expressed in the Foreword to the Annual Report for 2002. Then it noted that 'The Board continues to serve the international community in line with its mandate. Some distractions, however, come from groups that advocate legalization or decriminalization of drug offences, and others come from groups that favour a crusade focusing only on "harm minimization" or "harm reduction". Contrary to all available evidence, such lobbyists have persisted in proclaiming that there are safe ways to abuse drugs'.[14]

The thematic chapter goes on to explore what it believes are the 'principles of treatment interventions'. These are listed as follows:

1. Availability, accessibility, affordability, attractiveness and appropriateness of treatment
2. Screening, assessment, diagnosis and planning of treatment
3. Evidence-informed treatment
4. Human rights and patient dignity
5. Targeting of special sub-groups and conditions
6. Treatment and the criminal justice system (diversion from criminal justice, prison etc)
7. Community involvement, participation and patient orientation
8. Clinical governance of treatment services
9. Treatment systems: policy development, strategic planning and coordination of services

'Not every activity that results in the reduction of drug use can justifiably be labelled as treatment', notes the Board. While the general treatment principles may be similar across drug types and populations, each patient should ideally receive individually tailored treatment.

UNODC and WHO have developed joint international standards for treatment,[15] in order to support members states in developing effective and ethically-grounded services. However, the draft standards have been widely criticised for the inclusion of highly stigmatising, unsubstantiated and value-laden statements regarding drug dependence and people who use drugs.[16] UNODC and WHO have subsequently agreed to include an additional review process that includes people who use drugs to rectify this issue. The document evaluates a range of services including:

1. Community-based outreach
2. Screening, brief interventions and referral mechanisms
3. Short-term residential or in-patient treatment
4. Outpatient services
5. Long-term residential treatment
6. Recovery management
7. Interventions aimed at reducing adverse consequences of drug consumption. This package is harm reduction by any other name: The Board continues to be reticent regarding the use of this term
8. Other approaches, including interventions such as heroin-assisted treatment, supervised injection facilities, and so on. Essentially, these appear to represent those modalities that remain controversial amongst UN agencies and countries with conservative drug policy positions.

The issue of costs is raised once again by the Board. It notes that research in various settings have shown uniformly that treatment is highly cost-effective. Each dollar spent on treatment yields a return of USD 4 to 7 due to reduced crime-rates and costs for the criminal justice system. If savings for the healthcare services are included, total savings reach a ratio of 12 to 1 (Paras. 21-22). In addition to the economic value of treatment, the thematic chapter urges governments to integrate drug dependence treatment into the general healthcare system.

The chapter draws to a conclusion by considering treatment for special populations, such as children and adolescents, women, people in prisons and custodial settings, people with 'dual diagnosis'

(drug dependence and mental illness issues), and other special groups such as migrants and ethnic minorities facing specific difficulties. All of these groups require specific modalities of treatment, argues the Board.

The final section of the chapter sets out drug dependence as a human right, referring to article 12.1 of the International Covenant on Economic, Social and Cultural Rights, which describes 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (Para. 30). Drug treatment is, says the Board, justifiably considered an element of the right to health. This section includes discussion of the problem of mandatory treatment. In 'some cases', the Board informs us, 'patients are made to undergo treatment without their consent'. These cases often involve detention in prison or other carceral institutions. The chapter continues: 'Compulsory treatment … should be discouraged for the following reasons: (a) the evidence for their effectiveness is poor; (b) they threaten the health of people undergoing the treatment, including through increased vulnerability to HIV and other infections; and (c) they are in direct conflict with the human rights principles as stated in the International Covenant on Economic, Social and Cultural Rights' (Para. 34). It adds that many UN agencies advocate for the closure of compulsory drug detention centres. For example, a joint UN statement signed by 12 agencies was published in 2012, calling for 'States to close compulsory drug detention and rehabilitation centres and implement voluntary, evidence-informed and rights-based health and social services in the community'.[17]

The final section of the chapter summarises the previous discussion and sets it out in the form of a series of recommendations. By and large, these are, like the chapter itself, progressive in their tone; the Board is to be welcomed in producing this largely humane and evidential chapter on drug treatment.

Progress on human rights: But still narrow and disconnected

Building upon the momentum of previous years, the Report for 2017 gives notable and welcome prominence to the intersection between drug control and human rights, particularly in its key sections, including, as discussed above, in the Foreword. As considered in the foregoing, this is no great surprise considering not only the increasing references to the issue within debates at the CND and in recent high-level UN drug control documents, including the UNGASS Outcome Document, but also the confluence of several important anniversaries in 2018 alluded to earlier. As the Board is keen to point out, this year marks the seventieth anniversary of the adoption of the Universal Declaration of Human Rights in 1948, the twenty-fifth anniversary of the Vienna Declaration and Programme of Action adopted by the World Conference on Human Rights in 1993 as well as, in the field of drug control, the thirtieth anniversary of the adoption of the 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances; the most recent piece of hard law in the issue area.

Within this context, drug control and human rights is selected as one of the Report's Special Topics,[18] with the authors noting that 'These anniversaries provide a unique opportunity to reflect on the relationship between drug control and human rights and on the implications of that relationship for national responses to the world drug problem' (Para. 249). And among other aspects of the topic, within this section of the Report the Board goes on to reflect how in the Outcome Document 'the international community reiterated its commitment to respecting, protecting and promoting all human rights, fundamental freedoms and the inherent dignity of all individuals and the rule of law in the development and implementation of drug policies'. 'One of the operational recommendations contained in the outcome document' it continues 'is to *enhance the knowledge of policymakers* and the capacity, as appropriate, of relevant national authorities on various aspects of the world drug problem in order to ensure that national drug policies, as part of a comprehensive, integrated and balanced approach, fully respect all human rights and fundamental freedoms and protect the health, safety and well-being of individuals, families, vulnerable members of society, communities and society as a whole, and to that end encourage cooperation with and among UNODC, INCB, WHO and other relevant United Nations entities, within their respective mandates' (Emphasis added). It is also stressed how, 'The importance of protecting and advancing human rights principles and standards has also been fully recognized and reflected in all 17 Sustainable Development Goals of the 2030 Agenda for Sustainable Development, adopted by world leaders in September 2015' (Para. 250).

These are all clearly important 'high-order' points and it is true that in recent years at least, in particular

during the presidency of Werner Sipp (May 2015 to May 2017), the Board has indeed 'repeatedly stressed the importance of respecting and protecting human rights and fundamental freedoms as part of the effective implementation of the international drug control treaties' and 'continues to emphasize that for drug control action to be successful and sustainable, it must be consistent with international human rights standards and in general terms how this relates to aspects of the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights' (Para. 251).

In this vein, it is certainly positive that the publication highlights within the Special Topics section, among other things, the relationship between human rights obligations and access to essential medicines and internationally controlled narcotic drugs and psychotropic substances for medical purposes (Para. 252), the importance of the highest attainable standard of health and the right to the prevention and treatment of diseases, including in prison settings as well as gender specific interventions (Para. 253), the rights of drug offenders within the criminal justice system (Para. 254) and proportionality of sentencing (Para. 255). It is important that the Board continues to stress that 'Extrajudicial responses to drug-related criminality are in clear violation of the international drug control conventions' (Para. 256) and highlight that, although the 'determination of sanctions is a prerogative of States', it 'continues to encourage all States that retain the death penalty for drug-related offences to commute death sentences that have already been handed down and to consider the abolition of the death penalty for drug-related offences' (Para. 257). Indeed, it is quite appropriate that, along with a general reference to the importance of the rule of law and human rights in national drug policies (Para. 841 and Recommendation 5), both issues are given prominence within the Report's overall recommendations (Recommendation 8).

It is also interesting to see that in addition to the thematic chapter, the Report's Recommendations (6 & 7) include references to children, especially the need for states to 'protect children from drug abuse and prevent the use of children in the illicit production of and trafficking in illicit substances, in accordance with the Convention on the Rights of the Child, in particular article 33' – the only place in any core human rights treaty that mentions drugs.

While a welcome point – and one that is accompanied by a Recommendation reminding 'all States of the possibility of providing for education, treatment, rehabilitation and after-care measures in addition to, or as alternatives to, punishment of drug offences of a minor nature and offences committed by persons who use drugs' – it is nonetheless important that the Board is careful to avoid too narrow a construction of child's rights and considers their protection in parallel with other international human rights instruments and related state obligations. Beyond the often-deployed and simplistic justification for harsh law enforcement-oriented policy actions ostensibly designed to protect a child's right to a drug free world, a more contemporary and nuanced reading of Article 33 within a broader human rights context also raises important issues concerning states' approaches to implementing the right of a child to be protected from drugs, including age restrictions for harm reduction services and access to palliative care.[19] It can be argued that understanding these emerging complexities, as the President notes in his Foreword and indeed as is alluded to in chapter I, is part of the process of enhancing the knowledge of policy makers laid out in the Outcome Document and a dimension that should be stressed by the Board as it becomes more engaged with and reflective upon the issue of human rights.

Similarly, a broader and more holistic appreciation of the human rights implications of drug policy at the national level would also be beneficial within other parts of the Report, including those sections that comprise its main body rather than the Foreword, Special Topics and Recommendations. Indeed, while an improvement on recent years, the Report continues to display in places a disconnect between what we might consider its headline features and the more technical and detailed discussion in the pages in-between. Paradoxically, such a situation is somewhat analogous to the high-level rhetoric and agreed language of many member states and what actually goes on at the national level. In this regard, the INCB should certainly be commended for using its capacity to 'name and shame' and highlight its awareness of 'the continuing extrajudicial actions, including murder, taking place in relation to purported drug-related activities and/or crimes in the Philippines' (Para. 583); a statement that is, in line with the necessities of diplomatic protocol directly followed by a paragraph stating that 'The Board reminds all Governments that extrajudicial action, purportedly taken in pursuit of drug control objectives, is fundamentally

contrary to the provisions and objectives of the three international drug control conventions, as well as to human rights instruments to which all countries are bound' (Para. 584) and so clearly links to more prominent statements elsewhere within the publication.

It is, therefore, unfortunate that such an approach is not used in relation to those states where capital punishment for drug related crimes is still in use. In 2017 at least 33 countries and territories prescribe the death penalty for drug offences in law, of which 9 still have the death penalty for drug offences as a mandatory sanction.[20] Moreover, while noting concern regarding the forced displacement of 'persons belonging to minority ethnic groups in Rakhine State and by the humanitarian crisis it has caused' in Myanmar and Bangladesh and the associated problems regarding the provision of emergency medical supplies (Para. 160), there is once again no reference to internally displaced populations in a country like Mexico. As has been increasingly documented, the now long-running pursuit of a militarised response to the operation of drug trafficking organisations in Mexico has contributed to significant forced displacement. After an October 2015 delegation of the Inter-American Commission on Human Rights visited the country to study the situation the team concluded that 'one of the serious human rights violations that gave way (sic) to the different forms of violence from which Mexico is currently suffering has to do with forced internal displacement'.[21]

Further, despite mention of the use of glyphosate for the eradication of coca crops in Colombia, there is again no reference to the human rights implications of the practice. It is true that within the reporting period for the publication, the herbicide was only being dispersed via ground-based manual eradication. Nonetheless, rather than highlighting the human rights risks, health implications, including for women,[22] and the environmental damage of the practice, the Board chose to stress instead that 'The impact on protected areas of the illicit cultivation of coca bush remains a threat to biological diversity in the region' and 'The impact that the suspension of spraying might have had on the yield will be assessed in new yield studies planned for 2017' (Para. 541). Although both are clearly issues of concern, especially within the complex context of the Peace Process in Colombia, the chosen emphasis reflects an ongoing narrowness of focus and selectivity where human rights are concerned.

Public health: Steps forward (and backwards)

Access to harm reduction and drug dependence treatment

As remains, unfortunately, still unavoidable in any global survey of this type, the Report for 2017 contains many references to HIV/AIDS in relation to people who inject drugs – or in the Board's parlance 'persons who abuse drugs by injection' (for example, Para. 158). In providing an overview of state policies the INCB, for instance, outlines recent approaches in Myanmar – one of the countries selected this year for detailed evaluation in relation to overall treaty compliance (Para. 158) – as well as in India (Para. 656) and the European Union (Para. 792). Among references, direct or otherwise, to injecting drug use elsewhere in the Report, the Board encourages states to ensure adequate resources and access to treatment for these populations. This can be seen, for example, in relation to the Board's discussion of the situation in Central Asia, the Caucasus and South West Asia (Paras. 715 & 718).

The publication also contains references to the recent introduction of opioid substitution therapy in several African countries (including Algeria, Kenya, Mauritius, Morocco, Senegal, South Africa and the United Republic of Tanzania) as well as its consideration in Egypt and the Seychelles. Additionally, unlike the Report for 2016 when there was inexplicably no mention of the intervention, there is reference of the availability of needle and syringe programmes in Kenya, Mauritius and the United Republic of Tanzania (Paras. 407 & 408). Such an honest approach to describing the international situation is clearly welcome as is explicit reference to the fact that 'countries in Africa were still lagging behind in offering treatment for substance abuse'. (Para. 411). That said, and conscious of the more specific recommendations within the thematic chapter I, there are arguably missed opportunities to add specificity regarding the obligations of states vis-à-vis the 'health and welfare' of humankind under the drug control conventions. For example, the reference to 'de-addiction' centres in the State of Punjab, India, (Para. 656) and 'overcrowded psychiatric hospitals without specialized drug dependence services' and the existence of 'non-monitored traditional healers and faith-based facilities' in parts of Africa (Para. 411) should have been accompanied with reference to the need to apply accepted international treatment standards as discussed within chapter I.

Drug consumption rooms

It is certainly clear from other parts of the Report that the Board is not averse to offering detailed and targeted discussion in places that it deems worthy of attention. Indeed, reflecting the body's long-standing preference for giving attention to the repressive rather than the enabling character of the conventions in relation to public health, the Board devotes some space to the issue of drug consumption rooms (DCRs). In so doing, it is possible to identify a slight hardening of stance compared to last year's report. As IDPC highlighted in 2017, the Report for 2016 represented a positive shift in attitude, with the Board accepting that, under certain conditions, DCRs were permissible within the conventions.[23] This year, perhaps spurred on by a growth in uptake or discussion of the harm reduction intervention within several jurisdictions around the world, the Board rows back a little. Under the heading of 'Evaluation of overall Treaty Compliance', describing the situation in France (Para. 190), Canada (Para. 192) and Ireland (Para. 193), the Report reiterates the INCB's view 'that the ultimate objective of "drug consumption rooms" is to reduce the adverse consequences of drug abuse without condoning or encouraging drug use and trafficking' (Para. 189) and expresses its concerns about increasing the 'risk of drug abuse and trafficking' and 'unease' in relation to 'the provenance of substances used' in DCRs, since 'they are or may have been obtained illicitly' (Para. 190). It is unclear whether this has to do with the departure of Werner Sipp as president of the Board, who has been instrumental in the acceptance – under certain conditions – of DCRs by the INCB.

Significantly, however, within both the main body of the Report (Para. 189) and the overall Recommendations, the Board stresses the view that DCRs '*must provide or refer* patients to treatment, rehabilitation and social reintegration services' (emphasis added)[24] and highlights that 'Governments must also take note that the establishment of drug consumption facilities does not replace other initiatives aimed at preventing drug abuse, which remain of fundamental importance' (Paras. 189, 840 and significantly in Recommendation 4). As the Swiss delegation at the 2018 CND was keen to point out, the view that DCRs should guide individuals to treatment is problematic in that the very premise of a rights and evidence-based drug policy is that access to treatment must be a free and voluntary choice and consequently not a prerequisite of access to DCRs. Moreover, as in Switzerland, drug consumption rooms in other parts of the world operate as part of a holistic approach to public health rather than a replacement for other healthcare services. Yet, as can be derived from the statement that 'sites may reduce the adverse consequences of drug abuse *through* treatment, rehabilitation and reintegration' (emphasis added) (Para. 481), the Board appears to see little benefit in the operation of DCRs in and of themselves and in the harm reduction approach more generally.

Access to substances for medical and scientific purposes

What must be seen as a regressive step on DCRs is unfortunate since the Board's position on the availability of narcotic drugs and psychotropic substances for licit purposes remains positive. To be sure, beyond general discussion in the more prominent sections of the Report, more country specific references can also be found throughout the text. Thus, in addition mentions in the Foreword and Recommendations (10 & 16) highlighting the need for states to improve access to controlled substances for medical and scientific purposes – with the standard proviso concerning the prevention of diversion – and to supply the Board with appropriate data, the Report also flags up the situation in particular countries. This is generally the case in relation to those recently visited by an INCB Mission. As such, concerns are noted regarding Myanmar (Para. 59) and Egypt (Para. 204), and in terms of post-Mission follow-up, Tanzania (Para. 2014) and Venezuela (Paras. 220 & 221). In this regard it is also welcome to see the Board continuing to encourage states to engage with international guidance concerning estimating requirements for substances under international control and the importance of the International Import and Export Authorization System (I2ES) (Paras. 320-335), appropriate in-country training (for example Para. 337) and the INCB Learning Programme (Paras. 341-343). On the flip side of the access dilemma, over-prescription of opioid analgesics – particularly in the USA and Canada – it is also positive to see the Board highlight the issue as a 'Special Topic' (Paras. 259-277) and offer practical leadership, including highlighting the use of the *WHO Guide to good prescribing: A practical manual* (Para. 270).

Cannabis and ongoing policy developments

Medical cannabis

Mindful of the Board's continuing attention to access to internationally controlled narcotic drugs

and psychotropic substances for licit purposes, it is also interesting to note increased focus on medicinal cannabis within the Report for 2017, including as one of its Special Topics. Even though the issue has been gaining increased prominence in recent years, this is no doubt due in some way to the growing number of jurisdictions adopting or discussing adoption of some form of medical cannabis programme.[25] Indeed, the Board specifically notes that since the publication of its Annual Report for 2016, 'additional States have taken legislative or regulatory measures to provide for the medical use of cannabis or its derivatives for medical purposes' (Para. 174). Not unreasonably, amidst reference to the changing situation in some countries (for example, in Mexico, Para. 473, Argentina, Colombia, Paraguay and Peru, Paras. 513, 522-6 and Australia Para. 804), it is also noted at several points that 'While the 1961 Convention as amended, provides for the use by States of cannabis for medical purposes' the drug is strictly controlled within the treaty framework (for example, Para. 175). The Board also justifiably points out that 'All medical cannabis programmes must be developed and implemented under the full authority of the State concerned, in accordance with the requirements laid down in articles 23 and 28 of the Convention' relating to the establishment of a national cannabis agency to supervise and licence cultivation and control trade (Paras. 176 & 177 and Recommendation 12) and the responsibility to establish 'effective legislative and regulatory' frameworks to ensure 'rational, medically supervised use and to prevent diversion' (Para. 178).[26]

Additionally, the INCB is keen the stress that the place of cannabis under Schedules I and IV of the Single Convention – and hence the application of the most stringent control measures under the Convention – is 'due to the recognition by States of the particularly dangerous properties' of drugs within these categories (for example, Para. 175) This is a technically valid statement, but one that when read in isolation misses the broader context within which it should be considered in contemporary debates. Consequently, it is important for us to highlight briefly here not only the problematic nature of the classification, but also examine carefully the relationship between the Board's stance on the issue of medical cannabis and the state of the evidence.

Regarding the existing scheduling of cannabis within the conventions, it is true that the Report notes the recommendation of the thirty-eighth meeting of the WHO's Expert Committee on Drug Dependence (ECDD) in November 2016 to conduct a pre-review of the 'cannabis plant, cannabis resin, extracts of cannabis and tinctures of cannabis to establish their abuse and dependence potential as well as their therapeutic efficacy and safety for a number of specific medical conditions' (Para. 299). Such a process would have been difficult to ignore. It also takes note of the 2016 WHO report entitled 'The health and social effects of nonmedical cannabis use' (Para. 299). Further, the Board's discussion of 'medical purposes' within the Single Convention and the 1971 Convention (Paras. 294 & 295) and related detailed account of the role of the WHO in assessing the medical 'usefulness' of cannabis, responsibility of establishing the substance's liability to abuse and potential therapeutic advantages (Para. 295) and regulation, safety and quality assurance of medicines (Paras. 297-300 & Recommendation 12) are all useful and appropriate. What the Report fails to acknowledge, however, is that the ECDD's moves to examine the extant internationally controlled status of cannabis represents the first ever review of the scheduling of cannabis within the UN system.[27] Incredibly the last review took place under the auspices of the League of Nations in 1935 with the substance consequently having undergone no formal evaluation that meets currently accepted standards of scientific knowledge.[28] This fact goes some way to undermine the Board's overarching narrative that the current state of affairs rests upon 'the recognition by States of the particularly dangerous properties' of cannabis as a contemporary reality rather than a historic legacy.

It is perhaps unreasonable to expect the Board to acknowledge in the Report the historical background of the current double classification of cannabis within the Single Convention. Nonetheless, the INCB is arguably walking a fine line in relation to its mandate in the way in which it engages in some places in discussion of the therapeutic use of cannabinoids. Although its technical reading of related treaty articles is valid (for example, Paras. 287 & 288), the Board does not have a role in determining the state of the scientific evidence on medicinal use. As such, *unreferenced statements* concerning the inconclusiveness of evidence (Para. 289) and 'insufficient evidence for the therapeutic value of cannabinoids' (Paras. 289 and 290) come perilously close to the Board seeking to influence the debate and cast a chilling pall over the development of cannabis for medical purposes. This view gains credence when elsewhere in the Report the Board, having reminded readers of the 'indispensable' nature of narcotic drugs as laid out in the preamble of the Single Convention (Para. 301), recommends that 'practice is

based on available scientific evidence' (Para. 302 & Recommendation 11). As such, the INCB generates a self-reinforcing circular argument by placing itself as the arbiter of what is or what is not sufficient or conclusive scientific evidence.

This is not a new approach. Indeed, in response to the INCB's Report for 2003, something that is referred to in this year's publication (Para. 259), analysts argued that 'It is not up to the Board to decide whether scientific results are "conclusive" nor whether cannabis has medical usefulness. It is neither within their mandate nor their competence'. To take a position on the term 'medical and scientific purposes' as used in the conventions, the analysis continues, 'is to take a political stand'.[29] Moreover, it should be recalled that while the ECDD plays the lead role in recommending to the CND the status of substances within the international drug control framework,[30] its decisions are based on analysis of scientific research predominantly produced by and within member states and that is ultimately informing member state decisions on medical cannabis. Subtle suggestions that the INCB views any shifts towards medical cannabis schemes in a negative light can also be seen in its comments on events in Latin America. Here, again without referencing any evidence to support its claim it notes 'The availability of cannabis in the region continued to increase, driven by policies and legislative initiatives aimed at *permitting and regulating the medical* and non-medical use of cannabis in several States, thereby lowering the perception of risks associated with its use' (emphasis added) (Para. 513).

Legally regulated markets

As with its discussion of cannabis for medicinal use, the Board's focus on legally regulated markets also arguably treads a fine line between fulfilling its mandate and inappropriately influencing international debate.

Much of the discussion, including as part of the 'Evaluation of overall treaty compliance' section, concerning the shifting policy landscape comprises useful accounts of the state of affairs in an ever-growing range of jurisdictions. Consequently, attention is devoted to overviews of recent policy developments in Uruguay (Paras 182-3, 516 & 527) and Canada (Paras. 185 & 482). The Report also notes how it is continuing to 'monitor developments in the United States' in relation to ballot initiatives (Para. 187), and refers to decriminalisation in relation to religious use in Jamaica (Para. 188) and the establishment of the National Commission on Cannabis in Saint Kitts and Nevis (Para. 420). As a long-standing, if oscillating, point of attention over the years, ongoing INCB-Dutch dialogue around the 'coffee shops' is also given some attention (Paras. 162 & 164) as is the legislative activity in February 2017 towards 'authorizing and regulating the cultivation of cannabis for non-medical purposes' in the Netherlands (Paras. 163 & 186).[31] As is to be expected, all these instances are accompanied by various warnings from the Board – in different formulations and in relation to an array of regions – reminding states that 'any measures that permit or would permit the use of cannabis for non-medical purposes are in clear violation of article 4, paragraph (c), and article 36 of the 1961 Convention as amended, and article 3, paragraph 1 (a), of the 1988 Convention (for example, Paras. 163, 164, 180, 185, 428, 482, 528, 738). Indeed, such a view is given prominence in the Report's overall recommendations under the heading 'Promoting the consistent application of international drug control treaties' (Para. 839). Here states are reminded, quite appropriately, that 'in the outcome document of the thirtieth special session of the General Assembly, Member States reaffirmed their commitment to the goals and objectives of the three international drug control conventions' (Recommendation 2).

As has been discussed elsewhere, IDPC concurs with the view that legally regulated markets for the non-medical and non-scientific use of cannabis fall outside the current limits of the UN drug control conventions. Further, considering not only their status as signatories to the conventions but also their support for the far more recent Outcome Document, there is clearly a need for nation states already engaged or moving towards regulated markets at various levels of governance to reconcile their international obligations with emerging policy realities on the ground. It is also IDPC's view that the INCB should be deploying its expertise to help resolve current dilemma rather than simply repeating the mantra of 'treaties say no' and – intentionally or otherwise – influencing the mood music around the growing, although still admittedly low key,[32] international debates. Examples of subtle – yet perhaps significant – influence can be found in a number of places within the Report for 2017.

The first instance relates to the presentation of data. The Board quite validly includes within the Report references to recent research. Yet, the way it is on occasions presented seems designed to highlight or emphasise only the negative outcomes of changes in cannabis policy. It is clearly important

to cite the US National Institute on Drug Abuse reports highlighting possible increases in the illicit use of cannabis and related disorders in US states where medical cannabis schemes operate (Paras. 502 & 503) and other research around the increase in 'paediatric exposures' via edibles in the states of Colorado and Washington (Paras. 504-506). Related description of the development of public health and safety measures is certainly a positive inclusion (Paras. 5-7 & 508), as is reference to the Canadian Research Initiative in Substance Misuse's 'Lower risk cannabis use guidelines' (Para. 509). It is also good to see the Report note the publication of an overview of cannabis legislation in Europe by the European Monitoring Centre of Drugs and Drug Addiction and its conclusion that it is not 'clear whether legal penalties for cannabis use offences, which were increased or reduced in the countries concerned, have had any effect on the prevalence of cannabis use in those countries' (Para. 737). However, mindful of the imperative behind many policy shifts to safeguard public heath, it can be argued that a truly balanced representation of the issue would include emerging data pointing towards any positive outcomes in some dimensions,[33] as well as perhaps harms relative to alcohol and other substances. While, as the UNODC noted in its 2017 World Drug Report, a complex field of enquiry with a high degree of uncertainty,[34] inclusion of a wider range of research conducted during the INCB's census period would seem appropriate.

Our second concern relates to the Board's interpretation of international law and the development of positions around fundamental principles. When referring to legislative processes in Canada, the Report 'notes with concern' that draft legislation intended to authorize and regulate the nonmedical consumption of cannabis was introduced in the House of Commons in April 2017' (Para. 185). Such an approach to dealing with the policy choices of sovereign states with which the Board disagrees in order to generate anxiety and dissuade is well worn. On this occasion its concern has some legitimacy relative to the widely accepted boundaries of the drug control conventions. It is also fair that in several places, including in relation to Canada, the Board stresses 'that the limitation of the use of controlled substances to medicinal and scientific purposes is a fundamental principle to which no derogation is permitted under the 1961 Convention as amended' (Para. 582. Also see 180, 183 & 482).

Problems begin, however, when the concept of a fundamental principle vis-à-vis the Single Convention is extended to apply to international law more broadly. Indeed, although the proposition is not included within the Report for 2017, it seems to be the foundation of the Board's submission to the Canadian Senate Standing Committee on Foreign Affairs and International Trade in April 2018. In a forceful and ultimately misleading attempt to influence discussions within, and decisions of, the Committee the INCB brief claimed that the general obligation of the UN drug control treaties to limit drugs 'exclusively to medical and scientific purposes' has become a 'peremptory norm' of international law (*jus cogens*), 'absolute and unequivocal in nature', and 'could not be derogated from by a State Party'.[35] The brief asserts that any attempt by Canada to deviate from that principle in the case of cannabis would consequently be invalid under international law. It is not our role here to explore the submission and what it suggests about creative legal interpretation. This has been discussed elsewhere.[36] However, as with the issue of medical usefulness of cannabis, it is not the Board's remit to unilaterally decide on the application of international law more broadly. While it is the Board's mandate to ensure compliance with the treaties, when it comes to treaty reform, the Board should enter into constructive dialogue with the members states concerned and help to facilitate a solution the shifting realities of global drug control.

It is not always clear if letters or briefs sent out by the Secretariat have been approved by the elected members of the Board, nor if there is a protocol within the institution that clarifies the procedure of the INCB's outward correspondence. This raises the question of who, within the INCB, ultimately decides on the Board's positions in its communications with the signatories of the treaties – in particular in the case of politically sensitive issues that might interfere in internal parliamentary debates within member states. Likewise, as with the subtle backtracking regarding DCRs in the current Report as discussed above, it is unclear whether this is due to a 'redefinition' by the Board or by the Secretariat, which initially authors the Report to be submitted for approval by the Board. What is important for the purposes of this discussion is to highlight how important it is that the authority of the Report for 2017,[37] or any other year, is not used to bolster questionable legal positions that might have been arrived at unilaterally by the Secretariat.[38] Indeed, while as discussed here, the Report itself may contain some shortcomings, the presumption is that it has been approved by Board members themselves. The presentation of perspectives that may

not reflect the views of those individuals elected by member states through the Economic and Social Council ultimately risks undermining the INCB's own credibility and detracting from the constructive work it is undertaking and the many advances made in recent years.

Conclusion

Overall then, this year's Report should be regarded as a positive publication and in the main a welcome addition to the debate in the run up to the 2019 Ministerial Segment. As we have discussed here, it contains a great deal of constructive material and comment, particularly in relation to the twin issues of human rights and public health: issue areas that are wisely given additional prominence due to the proximity of several treaty anniversaries in the field of human rights and international drug control. IDPC is particularly pleased to see the Board continue to emphasise the importance of equitable access to substances for medical and scientific purposes and maintain its strong stand against use of the death penalty for drug offences and the application of extrajudicial measures. It is true that more progress could be made in reducing the disconnect within the Report between headline language in the Foreword, Special Topics and Recommendations and the fine-grained survey comprising the rest of the publication. Additional specificity relating to particular regions and in some cases – such as in relation to the continued use of the death penalty – individual states would assist the Board in highlighting the importance of human rights norms and obligations as they relate to the UN drug control conventions.

Similarly, it can be argued that the Board still maintains at times an unhelpfully narrow conceptualisation of human rights. Consequently, as IDPC has had cause to flag up the issue in previous years,[39] the omission of any comment on the human rights implications of, for example, crop eradication and drug policy-related violence and displacement appears even more incongruous within a publication where human rights are presented as a key and recurring theme. Such a narrow conceptualisation even goes some way to undermine the Board's well-intentioned invitation to 'all States to seize the opportunity provided by the anniversaries' of human rights instruments' and 'to reflect and to act on this important issue' (Para. 258). Indeed, where human rights are concerned, it is difficult to escape the realities of another disconnect: the gap between what states agree on and understand to be human rights at international meetings and within instruments like the Outcome Document and how these high order principles are applied in practice within their own territories. This is a challenge that, mindful of the broader UN system-wide tensions between state sovereignty and multilateral obligations, the Board must be prepared to confront on a long-term basis. This might be achieved via a more proactive approach to highlighting the enabling character of the treaty system. While the Board is quick to praise states for their law enforcement efforts (for example Para. 455), it seldom, if ever, does the same regarding public health and human rights.

Although not discussed directly within our analysis, the INCB should also be commended on its ongoing work to encourage states to improve the quality of their data collection and reporting. Indeed, beyond reference to access to internationally controlled substances for medical and scientific purposes noted here, the Report is scattered throughout with requests to states to develop data collection processes on issues like drug use prevalence, particularly – but not exclusively – in regions like Africa and Oceania (see, for example, Paras. 112-3, 213, 402, 797, 836 & 838). That said, and as we have noted elsewhere,[40] it would be even more constructive if the Board also considered calling for states to collect non-traditional data, particularly those relating to human rights and drug control. Such a move would not only advance the internal coherence of a piece of work like the Annual Report, but it would also go some way to assist member states to improve system-wide coherence as outlined in the Outcome Document and as referenced within this year's Report (Para. 250), particularly in relation to sister agencies like the UN Office of the High Commissioner on Human Rights.

Such a proposition does not seem unreasonable bearing in mind the significant, some might say progressive, advances that the Board has made in recent years. Beyond its engagement with the issue of human rights, as we noted here in relation to both the Foreword and chapter I, among other things the INCB has embraced the concept of complexity and moved appreciably away from the overt politicisation of a range of issues and the extension of its mandate beyond judicious bounds. That is not to say, however, that there are no longer problematic aspects of the Board's position as reflected in the Annual Report. As we have discussed in relation to DCRs and both the medical and recreational use of cannabis, the Board at times appears to retain a somewhat reticent position towards any deviation from the status quo, including when they involve

engagement with the harm reduction approach. On the latter, this is unfortunate bearing in mind the supportive positions held by other parts of the UN system that intersect with the issue of drugs. However, it is not always clear whether this reticence is the result of the composition of the Board or the position of the Secretariat that may have trouble adapting to the recent changes towards more 'lenient' positions of the Board itself.

Where maintenance of the status quo is concerned, however, the shift in some jurisdictions to regulated markets for the recreational use of cannabis remains a key point of contention. That such a policy option operates beyond the confines of the extant treaty framework certainly justifies the Board's repeated statements concerning treaty obligations and associated violations – if not dubious submissions to governmental committees. Nonetheless, in the spirit of its gradual shift away from its previously perceived role as an ardent and inflexible defender of the drug control treaties, one wonders to what extent the Board might contribute its considerable expertise to help better manage the current state of affairs and apparent transition to a new phase in the life of the drug control regime: a phase currently characterised by 'untidy legal justifications'[41] and, in the case of Canada, a candid admission of contravention of certain obligations related to cannabis.[42] In its mandated role to maintain constructive dialogue with member states (see for example, Para. 181), the time has surely come for the Board to move beyond its current stance and assist the admittedly still small number of states concerned, themselves among the owners of the conventions, to reconcile the realities of circumstances within their own borders with multilateral commitments made more than fifty years back. As long ago as 2008, the former UNODC Executive Director, Mr. Antonio Maria Costa, memorably remarked how moves away from the prohibition for non-medical and recreational purposes of a drug like cannabis had the potential to 'unravel the entire' international drug control system.[43] Such a view might be dismissed as hyperbole. Yet, with the UN drug control system arguably under greater strain than ever before, the Board would do well to proactively assist in the navigation of the uncharted waters ahead.

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27. Including at its fortieth meeting in June 2018. This was a specially convened ECDD session dedicated to carrying out pre-reviews of cannabis and a range of cannabis-related substances: http://www.who.int/medicines/access/controlled-substances/ecdd_40_meeting/en/
28. Danenberg, E., Sorge, L.A., Wieniawski, W., Elliott, S., Amato, L. & Scholten, W.K. (2013), 'Modernizing Methodology for the WHO assessment of substances for the international drug control conventions', *Drug and Alcohol Dependence*, **131**(3): 175-181
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30. Hallam, C., Bewley-Taylor, D. & Jelsma, M. (June 2014), *Scheduling in the International Drug Control System*, Series on Legislative Reform of Drug Policies, No. 25 (Transnational Institute), https://www.tni.org/files/download/dlr25_0.pdf
31. Regarding the situation in Europe, the Board is keen to stress that according to research from the European Monitoring Centre on Drugs and Drug Addiction 'European countries have not sought to legalize non-medical use of cannabis, and there is little evidence that proposals for changes in cannabis policy enjoy majority public support (Para. 737)
32. See: Bewley Taylor, D. & Hallam, C. (June 2018), *The 2018 Commission on Narcotic Drugs: Report of proceedings* (London: International Drug Policy Consortium), http://fileserver.idpc.net/library/CND-Proceedings-Report-2018_18.06.pdf. As accounts of the recent CND intersessional suggest, this period of relatively low-key reaction within the international community to moves towards regulated markets may be coming to an end. See: http://cndblog.org/2018/06/cnd-intersessional-25-june-2018/, particularly in relation to the position of the Russian Federation
33. See, for example, the data pulled together by the Drug Policy Alliance in: Drug Policy Alliance (January 2018), *From prohibition to progress: A status report on marijuana legalization – What we know about marijuana legalization in eight states and Washington D.C.*, http://www.drugpolicy.org/legalization-status-report
34. United Nations Office on Drugs and Crime (2017), *World Drug Report 2017*, (Booklet 1, p. 20), https://www.unodc.org/wdr2017/field/Booklet_1_EXSUM.pdf. Here the authors note, 'It is difficult to quantify the impact of the new cannabis legalisation as it seems that a combination of elements was already in the process of changing the cannabis use market in those jurisdictions when the legalization measures were put in place'
35. International Narcotics Control Board (November 2017), *Brief on the conformity of Bill C-45, An Act respecting cannabis and to amend the Controlled Drugs and Substances Act, the Criminal Code and other Acts as passed by the House of Commons*, https://sencanada.ca/content/sen/committee/421/AEFA/Briefs/2018-04-13_Brief_INCB_BillC-45_e.pdf
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37. See: Paras. 19 and 20 of: International Narcotics Control Board (November 2017), *Brief on the conformity of Bill C-45, An Act respecting cannabis and to amend the Controlled Drugs and Substances Act, the Criminal Code and other Acts as passed by the House of Commons*, pp. 3-4, https://sencanada.ca/content/sen/committee/421/AEFA/Briefs/2018-04-13_Brief_INCB_BillC-45_e.pdf
38. Suggestions that, on occasion, the Secretariat acts independently of Board members is not new. See, for example, Bewley-Taylor, D.R. (2012), *International drug control: Consensus fractured* (Cambridge University press), p. 270
39. See previous responses from IDPC to the INCB annual reports here: https://idpc.net/publications/2017/09/idpc-response-to-the-incb-annual-report-for-2018
40. ibid.
41. Bewley-Taylor, D., Blickman T. & Jelsma, M. (March 2014), *The rise and decline of cannabis prohibition: The history of cannabis in the UN drug control system and option for reform* (Transnational Institute & Global Drug Policy Observatory), p. 69, https://www.swansea.ac.uk/media/TNI-GDPO_Rise-and-Decline_web.pdf
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43. Costa, A.M. (7 July 2008), *Solidarity against drugs: Remarks to the "Beyond 2008" NGO Forum*, https://www.unodc.org/unodc/en/about-unodc/speeches/2008-07-07.html

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The International Drug Policy Consortium is a global network of non-government organisations that specialise in issues related to illegal drug production and use. The Consortium aims to promote objective and open debate on the effectiveness, direction and content of drug policies at national and international level, and supports evidence-based policies that are effective in reducing drug-related harm. It produces briefing papers, disseminates the reports of its member organisations, and offers expert advice to policy makers and officials around the world.

In this response, IDPC analyses the **2017 INCB Annual Report**, paying special attention to its foreword, its thematic chapter on treatment, as well as the cross-cutting issues of health, human rights and cannabis policies.