

**Statement by the International Drug Policy Consortium at the occasion of the 40th meeting
of the WHO Expert Committee on Drug Dependence**

Monday 4th June 2018

Thank you for the opportunity to address the Expert Committee on Drug Dependence.

I am making this statement on behalf of the International Drug Policy Consortium (IDPC) – a global network of more than 170 NGOs coming together to promote drug policies based on evidence, public health, human rights, human security, development and civil society participation.

IDPC welcomes the long-overdue pre-review of cannabis by the ECDD. Historically, cannabis was last reviewed in 1935 under the League of Nations-administered system of the interwar period. The 1935 review was strongly biased by racial and cultural stereotypes and prejudices, and was scientifically questionable. In the more than 80 years since that ‘review’, the science and the standards for conducting a rigorous critical review have evolved significantly. In this context, IDPC re-iterates the important role of the ECDD, which should remain free from political interference.

Decisions as to whether and how to schedule substances in the UN drug control system are not a matter of arcane abstraction. Such decisions impact directly upon national policy and criminal laws – and therefore on people’s lives, on public health, and on human rights. These stakes require that such decisions be based on the best available science and evidence.

It is crucial to acknowledge that, alongside the harms (and sometimes benefits) associated with cannabis use, there are also many harms and benefits associated with drug policy. The harms of a drug – to users and to the wider society – do not exist in isolation. The choice of drug policy, which may be significantly determined by the scheduling of a drug, can itself profoundly impact on the harms to the user and to the wider community. This is a concept that the WHO describes very clearly in its work on alcohol, and nicotine – but has been less prominent in its work on drugs controlled under the 1961 and 1971 conventions, which has tended to focus more narrowly on physical health harms.

Illustrating this distinction between drug use and drug policy harm, cannabis has long been the most widely used illegal drug in the world, and cannabis is also one of the substances most targeted by drug law enforcement efforts. In the United States, for instance, of the 8.2 million cannabis arrests between 2001 and 2010, 88% were for simple cannabis possession. A punitive legal framework that criminalises people who use cannabis has caused enormous harm and suffering, which cannot be ignored. Cannabis supplied via an unregulated illegal

market is also intrinsically riskier – being of unknown potency, having an unknown ratio of THC to CBD, and also having no quality control in terms of adulterants, pesticides, or fungal contamination.

In recognition of the harms being generated, or exacerbated, by the punitive approach to cannabis, policies around the world are currently undergoing rapid changes. This has included an accelerating growth in reforms to provide lawful access to cannabis for medical purposes. Today, 17 countries – or 41 jurisdictions if US states are counted individually – have adopted some form of medical cannabis access, reflecting increasing evidence of the benefits of cannabis-based medicines to treat a range of illnesses such as multiple sclerosis, epilepsy, or mitigating the side effects of chemotherapy.

A number of countries have also removed criminal sanctions for cannabis use or possession for personal use. These decisions have acknowledged that the evidence for a deterrent effect from criminalisation was weak, but the evidence of harm from mass criminalisation on the health and well-being of users was significant. It is worth noting that ending the criminalisation of all people who use drugs is advocated across the UN system, including the WHO.

Furthermore, since 2012, subnational and national jurisdictions have begun to legally regulate cannabis markets for non-medical or recreational use. So far, these have been established in nine US states, as well as in Uruguay, and soon in Canada.

Currently, cannabis is placed in Schedule I (highly addictive and liable to abuse) and Schedule IV (that is, certain substances included in Schedule I that are rarely used in medical practice) of the 1961 Single Convention on Narcotic Drugs. Confusingly, its main psychoactive compound, delta-9-THC or dronabinol, is also placed in Schedule II of the 1971 Convention, and several of its isomers even in Schedule I. This level of classification impedes scientific research on the active components of the plant because of the administrative difficulties scientists must go through to access these components for their research – hence severely limiting the amount of scientific literature on cannabis.

The assigning of cannabis to Schedules I and IV of the 1961 Single Convention was not based on a WHO scientific assessment, and its inclusion in schedule IV is inappropriate at the present time, given the widespread medical use of the substance and its derivatives. The imprecisions in the definitions of cannabis-related substances placed under international control, and the classification of its flowering tops, resin and extracts as “narcotic drugs” but its active compounds as “psychotropic substances”, represent inconsistencies that both the ECDD and the INCB have pointed out before. We hope this 40th ECDD meeting, apart from discussing the critical review and pre-review reports, will also take time to reflect on the anomalies in the history of international cannabis control, and will recommend

improvements with regards to the current definitions and division over the 1961 and 1971 conventions.

The ECDD has a key opportunity to start addressing the confusion around cannabis, by conducting an objective review of the plant and its derivatives – far from political and ideological interference. It is also IDPC's hope that, by conducting such a review, the ECDD will help to dismantle some of the myths associated with cannabis by collating all available scientific evidence on the effects – both positive and negative – of the plant and its derivatives. Crucially, we hope that the Committee will not ignore the profound impact of the legal and policy environment on cannabis-related harms and benefits to both users and the wider community – and will apply the same scientific rigor to considering policy impacts, as it does to pharmacological health risks.

To conclude, IDPC is pleased that the ECDD is moving forward in its review, and we hope that the process will move forward promptly towards recommendations for redefinitions and rescheduling based on scientific evidence. IDPC is pleased to be able to participate in this historic session, and will continue to follow the issue closely as the review proceeds.