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Implementation of the international drug control treaties

Statement submitted by the Multidisciplinary Association for Psychedelic Studies, a non-governmental organization in consultative status with the Economic and Social Council[**]

The Secretary-General has received the following statement, which is being circulated in accordance with paragraphs 36 and 37 of Economic and Social Council resolution 1996/31.

[*] E/CN.7/2020/1/Add.1.
[**] Issued without formal editing.

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Statement

Towards science-based scheduling of *cannabis sativa* and other controlled herbal medicines

Next year marks 60 years since adopting the Single Convention on Narcotic Drugs, aiming at “protecting the health and welfare” of humankind. Nevertheless, a decade ago, United Nations Special Rapporteur on the right to health reported: “current approach to controlling drug use and possession works against that aim.”[1]

The many scientific advances since 1961 would have been hard to imagine back then. In the case of the international scheduling of medicines, “classifications were made with insufficient scientific support to substantiate those classifications, as credible evidence exists regarding the medical uses of a number of them, such as cannabis for the treatment of certain epilepsies”,[2] as the United Nations CESCR reports.

Scheduling undertaken in the absence of science has stifled research into medical applications of cannabis. When “scientific research is impaired”[3] we lose our **right to enjoy the benefits of scientific progress and its applications**.

The WHO recently undertook extensive and unprecedented scientific assessments of the uses of cannabis and its derivatives in medicine. Their conclusions acknowledge several conditions for which enough evidence supports clinical use.[4] However, the current scheduling continues to hamper, not only research, but also the prescription, availability, and access to cannabis medicines for patients. Not taking action to facilitate access to these medicines for people who might need them for treatment is a “de facto denial of access to pain relief”, which, “if it causes severe pain and suffering, constitutes cruel, inhuman or degrading treatment or punishment”.[5] This breaches the “right of everyone to the enjoyment of the highest attainable standard of physical and mental health”, or **right to health**, set forth in the International Covenant on Economic, Social and Cultural Rights.

The Covenant mandates governments to “[create] conditions which would assure to all medical service and medical attention in the event of sickness.”[6] Because, additionally, “addressing the discrepancy in the availability of narcotic drugs for medical purposes is one of the obligations of Governments in complying with the drug-control conventions” ,[7] “adequate provision must be made to ensure the availability of narcotic drugs for [medical] purposes”,[8] including cannabis and its derivatives

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In 1935 the League of Nations had the opportunity to scientifically review cannabis but chose not to: instead, they assessed preparations with strychnine and other potent substances, and deemed the mere presence of cannabis extracts was responsible for the harmful effects.[9] In the 1950s WHO relied on weak and biased evidence such as

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[1] A/65/255.

[2] E/C.12/GC/25.

[3] Ibid.

[4] WHO Expert Committee on Drug Dependence considers that “preparations of cannabis have shown therapeutic potential for the treatment of pain and other medical conditions such as epilepsy and spasticity associated with multiple sclerosis, which are not always controlled by other medications.” The Experts also noted a number of indications linked to different preparations, extracts or products made out of cannabis: anorexia associated with AIDS, nausea and vomiting in chemotherapies, neuropathic pain, chronic cancer pain, Lennox-Gastaut/Dravet-syndromes, neonatal hypoxic-ischaemic encephalopathy, perinatal asphyxia, etc. WHO Technical Report Series 1018.

[5] A/HRC/10/44.

[6] Article 12.2(d).

[7] E/INCB/2015/1/Supp.1.

[8] Preamble of the 1961 Convention.

[9] Pp. 7–9, in Joint Civil Society Contribution, 40th WHO-ECDD, Geneva, 2018.

"feeling among the South African police of a relationship between cannabis addiction and crime"[10] to declare that "there should also be extension of the effort towards the abolition of cannabis from all legitimate medical practice".[11]

The first sound, independent, methodological and comprehensive scientific assessment occurred in 1990, for THC, and resulted in its rescheduling (from Schedule I to Schedule II of the 1971 Convention).[12] But it was only in 2018 that the first-ever such science-based assessment was undertaken for pharmaceuticals and phytopharmaceuticals derived from *cannabis sativa*.

The outcome of WHO's assessments mandates an update of the seriously outdated scheduling status of cannabis, for the benefit of science, clinical practice, and correcting the record with regard to the **rights of indigenous peoples** to plants that "have been used in traditional medicine in some countries for centuries".[13]

Treaties need to respect the history of humankind. In 2020, just like in 1920, cannabis medicines are a reality for hundreds of thousands of patients in most member States of the Commission. Cannabis medicines include phytopharmaceuticals (raw herbal formulas, extracts, tinctures and other prepared botanical drugs) as well as compounded pharmaceutical preparations (either from naturally obtained compounds or synthetic cannabinoids as active pharmaceutical ingredients). All are valid. All can provide relief from pain and suffering, in specific indications. The diversity of formulas offers doctors and health-care practitioners a broader range of therapeutic instruments to address the unique needs of each individual patient.

Ensuring access to and availability of these medicines while addressing their diversion and use-disorders remains a common and shared responsibility of all nations. Nevertheless, pharmaco-vigilance, efficient training, education, and frontline medical professionals play a significant role that international control doesn't. Scheduling isn't the *alpha*-and-*omega* of effectively addressing adverse effects.

* * *

WHO recommendations – while pointing out that evidence shows cannabis medicines are lower risk than other substances in Schedule I, 1961 Convention – suggests a consensual, depoliticized way forward, agreeable to all parties, that maintains a high level of control and respects the sovereignty of member States, in an effort to meet their social, economic, and administrative concerns.

Governments are expected to make an effort to meet WHO's global, public health concerns and science-led advice. Policy coherence is one of the commitments of the Sustainable Development Goals[14] and of the complementary, mutually reinforcing UNGASS 2016 operational recommendations.[15]

Updating scheduling based on science is the way for policy to cohere.

The recommendations are a test for the conventions: they seek to make them effective and fit for purpose, by facilitating access and availability of controlled medicines with proven efficacy and safety and a well-documented history of use in both indigenous and Western systems of medicine. WHO sets the historical record straight, while enhancing human rights: to health, to benefit from science, to access medicines

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[10] WHO Technical Report Series 95.
[11] Ibid.
[12] *Crimson* Digest (vol. 1), Paris, 2018.
[13] E/INCB/2001/1 §208.
[14] A/RES/70/1.
[15] A/RES/S-30/1.

needed for one's medical care, but also the prevailing rights of indigenous peoples[16] and traditional communities.[17]

Opposing the recommendations wouldn't weaken WHO. It would deride the Commission and trivialize the Conventions. It wouldn't stop the trend of national and local policy reforms allowing medical access to cannabis: all would continue to unfold outside the scope of the Conventions.

Civil society and patients will be fine either with a Convention-compliant system or with sui generis systems taking advantage of the flexibilities in interpreting the treaties. Rejecting the recommendations would send a clear message: the treaty system is not fit for regulating natural traditional medicines that have shown beneficial and manageable therapeutic properties in centuries of experiential evidence, and are nowadays rediscovered by modern clinical research. This applies to cannabis under the 1961 Convention but also coca leaves, as well as psilocybin, mescaline, dimethyltryptamine under the 1971 Convention.

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In 2008, UNODC convened +600 NGOs from 116 countries in Vienna. They adopted an unprecedented consensus statement[18] where the Commission was asked, among others, to:

(a) Develop a common standard against which demand, harm and supply reduction activities can be measured in terms of their efficacy and outcomes, including analysis of the unintended consequences of the drug control system,

(b) Ensure that those who are most affected by drug use and drug policies are meaningfully and actively involved in the development of policies and programmes,

(c) Evaluate its own work and policies and identify ways in which its effectiveness and impact might be improved, including decision-making by vote in accordance with the rules of procedure of ECOSOC and its functional commissions, as appropriate,

(d) Ensure that its decisions are guided by the best and most relevant data and evidence, including data on psychological health, the transmission of blood-borne infections and data on compliance with human rights norms.

Instruments such as the SDGs and the reviews of the Annual Report Questionnaire help the system find ways towards common standards to measure efficacy and outcomes of drug policies. However, the other three areas have seen little progress so far. On (b), the two-year discussions have not seen any consultation with patients or those affected by cannabis use or policies. If the Commission rejects WHO recommendations, it would be a clear failure to accomplish (c) and (d).

* * *

Accepting WHO's recommendations would be a first step in the partnership between governments and civil society to build tomorrow's health-care systems together.

This is why we, scientists, researchers, public health specialists, physicians, nurses, caregivers, join INCB[19] and WHO in calling all Nations to support these recommendations as a step towards a rules-based international order led by evidence and human rights.

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[16] A/RES/61/295, article 24 "Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals".

[17] Precisions on traditional medicine within the 1961 Convention can be found p. 111, §12, United Nations Publication E.73.XI.1

[18] Final-Act, Beyond-2008 Forum, 9 July 2008

[19] Statement, Dr. de Joncheere, INCB-President, Sixty-third CND, Second-intersessional, 8 October 2020.

Supporting the statement:

AIDS Foundation East-West
Ethiopia Africa Black International Congress Church of Salvation
Forum on Drug Policies
Help Not Handcuffs
International Center for Ethnobotanical Education
Research and Service
Latinoamerica Reforma Foundation
Students for Sensible Drug Policy
The Society of Reason
YouthRISE

Also supporting the statement:

Public-Organization-Against-AIDS (Azerbaijan)
Science-for-Democracy (Belgium)
Moms-Stop-The-Harm (Canada)
Asociacion-Medica-Colombiana-de-Cannabis-Medicinal; Elementa-DDHH (Colombia)
Asociace-péče-o-seniory; Společnost-Podané-ruce (Czechia)
Eurasian-Women's-Network-on-AIDS; Women-for-health (Georgia)
International-Association-for-Cannabinoid-Medicines (Germany)
Rights-Reporter-Foundation (Hungary)
Eumans; Luca-Coscioni-Association (Italy)
ALE-Kazakhstan-Union-of-People-Living-with-HIV; Общественное-объединение-Амелия (Kazakhstan)
Eurasian-Harm-Reduction-Association (Lithuania)
Integración-Social-Verter (Mexico)
PULS (Moldova)
Cannagenethics-Foundation; Correlation-European-Harm-Reduction-Network; Drugs-in-Debat (Netherlands)
PREKURSOR-Foundation-for-Social-Policy (Poland)
Romanian-Association-Against-AIDS (Romania)
RuNPUD (Russian Federation)
Drug-Policy-Network-South-East-Europe (Serbia)
ODYSEUS (Slovakia)
Stigma-Association-for-harm-reduction (Slovenia)
Tshwane-Region3-Traditional-Health-Practitioners (South Africa)
FAAAT; Observatorio-Español-de-Cannabis-Medicinal (Spain)
Cannabis-Consensus-Schweiz; Swiss-Society-for-Cannabis-in-Medicine (Switzerland)
Asia-Catalyst (Thailand)
ALLIANCE.GLOBAL; Sources-of-Public-Health; VOLNA (Ukraine)
Drug-Science (United Kingdom of Great Britain and Northern Ireland)
International-Cannabis-Farmers-Association; Origins-Council; Society-of-Cannabis-Clinicians; Treatment-Action-Group (United States of America)