

5.0 General questions

China

Although important, these questions do not fall within the mandate of the Expert Committee on Drug Dependence (ECDD) as defined within the Conventions. It could be worth considering having these discussions in a different forum.

Cannabis is a scheduled substance under the 1961 Convention. The scheduling system within the International drug control conventions is meant to prevent abuse, dependence and harm to health caused by psychoactive substances such as cannabis, including in youth populations.

Japan

With regard to synthetic cannabinoids, the Committee considered the issue of whether it will also be necessary to move those synthetic cannabinoids currently placed in Schedule II of the 1971 Convention (such as JWH-018, AM-2201, and ADB-CHMINACA) to the 1961 Convention if the recommendations regarding the transfer of dronabinol are adopted. However, the Committee recognised that while these synthetic cannabinoids have some pharmacological effects similar to delta-9-THC, there are important differences. In particular, the Committee noted that the synthetic cannabinoids have effects more similar to amphetamine and amphetamine analogues than to delta-9-THC (such as the cardiovascular and stimulant effects) and other effects more similar to hallucinogens such as LSD than to delta-9-THC (such as the extent and likelihood of hallucinations). Both amphetamine and LSD are scheduled under the 1971 Convention.

Nigeria

1 & 2. There is evidence from a large number of clinical trials on the therapeutic effectiveness and use of cannabis preparations. In this regard, a number of cannabis-based medicines have been granted marketing authorisations in a number of countries including for the management of muscle spasticity in multiple sclerosis and for the treatment of epilepsy. Some of this is summarised in the critical reviews prepared for the 41st ECDD meeting and available on the WHO website: https://www.who.int/medicines/access/controlled-substances/ecdd_41_meeting/en/.

Another source of such information can be found in the US National Academy of Science review “The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research”

3 & 4. The issues raised in the questions do not fall within the mandate of the ECDD as defined within the Conventions. The ECDD recommendations are informed by thorough review of scientific evidence and are formulated as clearly as possible and on the basis of scientific facts. The ECDD is only able to use the criteria as set out in the Conventions and cannot include for consideration other more general matters.

5. It is assumed this question refers to the availability of preparations proposed to be controlled under Schedule III of the 1961 Convention. In reaching its recommendation, the Committee applied the criteria for control of preparations under Schedule III as set out in Article 3 para 4 of the 1961 Convention. The availability of a medicine is not part of the criteria that should be used to determine the suitability of a preparation for inclusion in Schedule III and was therefore not considered by the Committee.

6. The WHO's cannabis recommendations are the product of a thorough and multi-step scientific process with involvement of Member States and stakeholders in accordance with the WHO Expert Advisory Panel Regulations and the WHO Guidance on the WHO review of psychoactive substances for international control.

WHO does not plan to revisit these recommendations through the ECDD or otherwise. WHO awaits the CND's consideration of these recommendations and the CND's guidance and continues to stand available to support discussions as guided by the CND.

Pakistan

The issue of available scientific evidence concerning the therapeutic use of cannabis preparations has been addressed above. The ECDD is only able to use the criteria as set out in the Conventions and cannot include for consideration other more general matters such as the outcome of a risk benefit analysis of research and use of cannabis preparations.

Russian Federation

1. For a number of conditions, there is now evidence that cannabis preparations have therapeutic advantages not possessed by other substances. This is also being recognised by national regulatory authorities in a number of countries (currently more than 30 countries) that have approved cannabis-based medicines for the management of muscle spasticity and the treatment resistant epilepsy. Such approvals normally requires the demonstration of therapeutic advantage.

2. There is evidence that cannabis preparations have advantages for some medical conditions that are not provided by other existing medications. These have been extensively documented in numerous publications that cannot be reviewed in the space available here. However, reference can be made to analyses such as the one from the US National Academy of Science review "The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research" made the following conclusions (p.128):

There is conclusive or substantial evidence that cannabis or cannabinoids are effective:

- For the treatment of chronic pain in adults (cannabis)
- As antiemetics in the treatment of chemotherapy-induced nausea and vomiting (oral cannabinoids)
- For improving patient-reported multiple sclerosis spasticity symptoms (oral cannabinoids)

There is moderate evidence that cannabis or cannabinoids are effective for:

- Improving short-term sleep outcomes in individuals with sleep disturbance associated with obstructive sleep apnea syndrome, fibromyalgia, chronic pain, and multiple sclerosis (cannabinoids, primarily nabiximols).

They also documented conditions for which cannabis preparations were not effective or for which there was insufficient evidence. The research supporting these conclusions is extensively described and analysed in that publication.

A risk benefit analysis for cannabis goes beyond the mandate of the Expert Committee on Drug Dependence (ECDD) as defined within the Conventions. The ECDD is only able to use the criteria as set out in the Conventions.

3. In its recommendations, the Committee made an observation about the impact on research of scheduling, but this was not critical to any of the decisions made. In particular, the decision to recommend deletion of Cannabis and Cannabis Resin from Schedule IV was based both on the level of liability to abuse and to produce ill effects of cannabis and preparations of cannabis and the therapeutic value of cannabis preparations, while recognising the characteristics of substances currently included in Schedule IV.

Reference can be made to analyses such as the one from the US National Academy of Science review “The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research” that addresses the Challenges and Barriers for Conducting Cannabis Research, p.377 to p.394.

4. Cannabis has never been subject to a formal review by the WHO Expert Committee on Drug Dependence (ECDD) since its original placement within the International Drug Control Conventions. The reasons for the review have been previously explained. For example, in the report of the 41st ECDD meeting it was noted:

In response to CND Resolution 52/5 (2009), which requested an updated report on cannabis from WHO (subject to the availability of extrabudgetary resources) and to CND Resolution 50/2 requesting WHO, in consultation with INCB, as appropriate, to undertake a review of dronabinol and its stereoisomers when additional information became available, and recognizing that a formal review of the scheduling of cannabis had not previously been carried out by the ECDD, WHO undertook to review the scheduling of cannabis and cannabis-related substances.

A review of the medical use of cannabis and cannabis preparations was included in the review process that informed the ECDD deliberations. Information on this review can be found in the critical review reports for the 41st ECDD meeting available at the following link:
https://www.who.int/medicines/access/controlled-substances/ecdd_41_meeting/en/

5.1 Cannabis and cannabis resin

Colombia

The 1961 Convention uses the following definition: “Cannabis resin” means the separated resin, whether crude or purified, obtained from the cannabis plant. A resin is a substance that is exuded from a plant. It is produced naturally, differentiating it from substances such as butane hash oil which are produced using a solvent. Cannabis resin can be considered part of the cannabis plant and is currently controlled in the same way as the cannabis plant. The Committee did not seek to change this principle.

Russian Federation

1. With respect to Schedule IV, it should be recognised that only a small subset of the drugs in Schedule I are also included in Schedule IV. Apart from cannabis and cannabis resin, they comprise a subset of opioids that have been considered at various times to be particularly liable to abuse and to produce ill-effects and to have no substantial therapeutic advantages. The drug most recently

included in Schedule IV is carfentanil, an extremely potent and dangerous opioid that is not used in human medicine. As noted, neither opium nor coca leaf are included in Schedule IV. The Committee considered that neither the liability to abuse nor the liability to produce ill-effects of cannabis were commensurate with the other substances, such as carfentanil, in Schedule IV. The Committee also recognised that in 1961 cannabis and cannabis preparations were not recognised to have any therapeutic use or therapeutic potential. There is now evidence that cannabis preparations have therapeutic advantages not possessed by other substances. That evidence was discussed in response to a previous question, under Item 5.0 above.

Based on both the level of liability to abuse and to produce ill effects of cannabis and preparations of cannabis and the therapeutic value of cannabis preparations, while recognising the characteristics of substances currently included in Schedule IV, the Committee considered that cannabis was not similar to these substances and therefore should not be included in Schedule IV.

2. There are now a number of cannabis-based preparations containing dronabinol and a combination of dronabinol and cannabidiol approved for various medical indications in a number of countries. For approval of the medical use of these preparations extensive safety data has been provided. Some of this information is also in the public domain through the published results of a range of clinical trials. While there are adverse effects with such medications as there are with any medications, these have not been considered so severe as to prevent medical use.

The ECDD has never recommended smoked cannabis for medical use and any recommendation for or against such use would be outside the mandate of the ECDD.

3. The removal of Cannabis and Cannabis Resin will not change the level of international control. The international control measures in place for a drug included in Schedules I and IV are the same as those for a drug in Schedule I. Therefore, there would be no weakening of the international control of cannabis if it was included only in Schedule I. For Schedule IV drugs, additional control measures can be enforced at national level by individual countries, but such measures are not mandated.

A risk benefit analysis of the type proposed is beyond the mandate of the ECDD based on the requirements of the Conventions.

4. The rationale used by the ECDD regarding Schedule IV has been explained in the answer to question 1, above. With regard to the issue of impact on research, the Committee made an observation about the effect of scheduling, but this was not critical to the decision to recommend deletion from Schedule IV. This question has been addressed in question 3 of Item 5.0 above.

Singapore

The international control measures in place for a drug included in Schedules I and IV are the same as those for a drug in Schedule I. However, for Schedule IV drugs, countries are encouraged to consider enforcement of additional national control measures. The controls on medical access and research for drugs in Schedule IV are therefore under the control of each individual country. Some countries may choose to impose a greater level of control that impairs research and medical use and there was some information that impairment of research do occur in some countries for substances in Schedule IV.

Countries may also be mindful of the interpretation of Schedule IV as described in the Commentary on the Single Convention on Narcotic Drugs, 1961. On p.94 it is noted that the Technical Committee of the Plenipotentiary Conference which adopted the treaty described the substances listed in Schedule IV as those:

(a) Having strong addiction-producing properties or a liability to abuse not offset by therapeutic advantages which cannot be afforded by some other drug; and/or

(b) For which deletion from general medical practice is desirable because of the risk to public health.

The criterion set out in (b) could be interpreted as an indicator that substances included in Schedule IV should never be used for medical use. Furthermore, in para 7 on p.95 it is noted that the recommendation of WHO and the decision of CND to include a drug in Schedule IV will be largely motivated by a desire to eliminate it from medical practice. The deletion of Cannabis and Cannabis Resin from Schedule IV would maintain the same level of international control but without the implication that cannabis, cannabis resin and preparations made from them should never be used for medical purposes.

5.2 Delta-9-tetrahydrocannabinol (dronabinol)

China

Recommending that a substance be moved from one convention to another should generally be made only if specific new control measures are necessary in order to decrease the extent or likelihood of abuse or the use of the substance in illicit drug manufacturing, as indicated in the "Guidance on the WHO review of psychoactive substances for international control" through its paragraph 45.

Consistent with this principle, the Committee recommended that dronabinol be scheduled under the 1961 Convention in particular because of illicit preparations containing high levels of delta-9-THC, such as butane hash oil. The existence and use of such high potency and harmful products is a relatively new phenomenon. Currently, there is a lack of clarity as to whether these substances such as butane hash oil should be controlled as preparations of cannabis (under the 1961 Convention) or as preparations of dronabinol (under the 1971 Convention).

The reasons for the recommendation on dronabinol are described in the report of the 41st ECDD. The main criterion for recommending that dronabinol be included in Schedule I of the 1961 Convention was the criterion of similarity in liability to abuse and to produce ill effects to cannabis and preparations of cannabis. It is also the case for opium and coca leaf that the plant and the drug that is included in the plant (morphine and cocaine, respectively) are controlled within the same schedule and the same 1961 Convention.

After the Committee consulted with INCB, it noted that:

... placing Δ^9 -THC under the same Convention and in the same schedule as cannabis, Schedule I of the 1961 Single Convention on Narcotic Drugs, would greatly facilitate the implementation of the control measures of the Conventions in Member States.

While this was not a criterion for the recommendation, and did not directly influence the recommendation, the ECDD did acknowledge that there were advantages to Member States should this recommendation be adopted.

The isomers of THC included in Schedule I of the 1971 Convention and recommended to be included in Schedule I of the 1961 Convention, along with the isomer dronabinol ((-)-trans- Δ^9 -THC), comprise

a varied group of substances, most of which do not occur naturally. For none of them is there convincing evidence that would satisfy the criteria for inclusion in Schedule I of the 1971 Convention, as they are currently scheduled, and for at least one there is no such evidence. However, as the group of substances that is currently scheduled under a single drug name (tetrahydrocannabinol), they can be considered similar to dronabinol, as some do have dronabinol-like properties based on the limited evidence available.

It is also the case that as isomers of dronabinol they are very difficult to differentiate from dronabinol through usual chemical identification processes. The Committee took advice from INCB and recognised that the control of dronabinol would be compromised if these isomers were separately scheduled from dronabinol.

The reassignment of dronabinol and tetrahydrocannabinol from the 1971 Convention to the 1961 Convention will not relax controls on these substances.

Preparations in Schedule III of drugs controlled in Schedule I or Schedule II of the 1961 Convention are exempted from some of the requirements for control of those drugs. However, they are still subject to a significant level of control.

Article 2 para 3 of the 1961 Single Convention states:

Preparations in Schedule III are subject to the same measures of control as preparations containing drugs in Schedule II, except that article 31, paragraphs 1 (b) and 3 to 15 and, as regards their acquisition and retail distribution, article 34, paragraph (b), need not apply, and that for the purpose of estimates (article 19) and statistics (article 20,) the information required shall be restricted to the quantities of drugs used in the manufacture of such preparations.

This makes clear that the exemption for Schedule III products is for some of the requirements only, and not an exemption from control. This exemption is only for preparations containing dronabinol which are compounded as pharmaceutical preparations with one or more other ingredients and in such a way that dronabinol is not readily recoverable. Each Member State can define what qualifies as a pharmaceutical preparation in their country.

The placement of cannabis pharmaceutical preparations under Schedule III of the 1961 Convention will not result in relaxation of controls on cannabis and cannabis resin.

Japan

The Committee considered that it was not necessary to recommend a maximum content of dronabinol, as it was specified that pharmaceutical preparations of cannabis and dronabinol in Schedule III would require that delta-9-THC is not readily recoverable. By comparison, almost all the substances in Schedule III currently (with opium as an exception) are readily recoverable.

Russian Federation

The Committee is able to recommend deletion of a substance from a schedule of a convention and also to recommend adding a substance to the schedules of a convention. The recommendations of the ECDD were to delete dronabinol from control under the 1971 Convention and add it to the Schedules of the 1961 Convention and similarly for the isomers.

The “Guidance on the WHO review of psychoactive substances for international control”, through its paragraph 45, provides guidance on the circumstances under which the WHO ECDD may recommend adding a substance to one convention and deleting it from another. For WHO and the ECDD this Guidance, endorsed in 2010 by the WHO Executive Board, has authority.

Singapore

1) The amphetamine like effects of synthetic cannabinoids include the cardiovascular effects, the ability to produce psychosis and stimulant effects. The cardiovascular effects of delta-9-THC are relatively mild, principally a mild tachycardia. In contrast, synthetic cannabinoids can produce a pronounced tachycardia (like amphetamine) and cardiac arrhythmia. Fatalities have occurred due to the cardiac effects of synthetic cannabinoids as they have with amphetamine.

Synthetic cannabinoids can produce a pronounced psychotic state that requires hospitalisation. This is a feature of cases of non-fatal intoxication due to synthetic cannabinoids, as is the case with amphetamine. In comparison, delta-9-THC has relatively mild psychotic effects.

Agitation and aggression have been features of cases of non-fatal intoxication due to synthetic cannabinoids, as is the case with amphetamine. In comparison, delta-9-THC does not produce such effects.

2) It is not proposed that synthetic cannabinoids currently under control under the 1971 Convention be moved to control under the 1961 Convention. However, should the recommendations be adopted, synthetic cannabinoids considered in the future will be examined with regard to their similarity to delta-9-THC (controlled under the 1961 Convention if the recommendations are adopted) and to other synthetic cannabinoids (in Schedule II of the 1971 Convention) as well as other substances controlled under the 1971 Convention; recommendations for scheduling will then be made appropriately.

5.3 Tetrahydrocannabinol (isomers of THC)

United States

(In the consolidated questions this question has been incorrectly placed and should have been in section 5.2, above, but is answered here for consistency with the structure of the consolidated questions)

It has been previously noted that current international regulation is consistent with the exemption from control of cannabis grown for industrial or horticultural purposes even though such cannabis contains delta-9-THC which is controlled under the 1971 Convention. It is understood that the same would apply if delta-9-THC was controlled under the 1961 Convention.

5.4 Extracts and tinctures of cannabis

China

If a preparation such as butane hash oil is made using the cannabis plant, then that preparation will contain elements of the plant. As parts of the plant are retained in such preparations, they are considered preparations of the plant.

Using the language of the question, mixtures made from cannabis are also mixtures containing cannabis.

There does not therefore seem any need to retain extracts and tinctures of cannabis.

Colombia

1) If a preparation is made using the cannabis plant, then that preparation will contain elements of the plant. As parts of the plant are retained in preparations, they are considered preparations of the plant.

2) Whether the tinctures and other products cited in the question are classified as preparations of cannabis or of cannabis resin depends on whether cannabis or cannabis resin was used as the starting product. In practice, it will not be possible to determine which was used and therefore it is important that cannabis and cannabis resin are not separated and not potentially scheduled under different levels of control.

3) Currently, tinctures, oils and other products cited in the question can be considered either as (a) preparations of delta-9-THC (dronabinol) or (b) preparations of cannabis or (c) as extracts and tinctures of cannabis. This means that they could be controlled under (a) the 1971 Convention Schedule II, or (b) the 1961 Convention Schedules I and IV or (c) the 1961 Convention Schedule I. The proposed changes will not alter the fact that tinctures, oils and other products cited in the question could be considered as preparations of delta-9-THC (dronabinol) or of cannabis, but will remove the ambiguity as to the level of control as they will be controlled under the 1961 Convention Schedule I irrespective of what type of preparation they are considered to be.

Similarly, with the isomers of THC, the ambiguity as to the type of control will be removed by the recommended changes.

4) As noted above, there is currently a great degree of ambiguity both in respect to whether a preparation of cannabis is a narcotic drug (as it is derived from cannabis) or a psychotropic drug (because it contains delta-9-THC) and, if a narcotic drug, whether it is a preparation or an extract or tincture. The proposed changes will mean that these preparations will all be considered narcotic drugs controlled under the 1961 Convention in Schedule I.

5.5 Cannabidiol Preparations

China

1) The evidence regarding the lack of psychoactive effects of cannabidiol is summarised in the critical review published as part of the 40th meeting of the ECDD in 2018. In brief, that evidence includes the following: Cannabidiol

- does not bind to CB1 receptors
- does not produce THC-like effects in a range of animal models
- does not produce THC-like effects in humans
- shows no evidence of abuse potential in human studies; for example, in a measure of subjective effects it shows no difference from placebo.

More detail as well as references can be found in the critical review available at:

(https://www.who.int/medicines/access/controlled-substances/ecdd_40_meeting/en/).

In clinical trials of cannabidiol that contain trace amounts of THC there is no evidence of THC effects or of abuse potential. These trials are also discussed in the critical review.

2) There are no known cannabinoids with sufficient pharmacological activity and that occur at sufficient concentrations in cannabis that would produce effects due to their presence in a cannabis preparation that was predominantly cannabidiol. There is therefore no need to restrict other cannabinoids.

The only other controlled cannabinoids (excluding synthetic compounds) are the isomers of delta-9-THC. These do not occur naturally in the cannabis plant (one may occur at very low concentrations, but this is not yet certain).

European Union

The recommended exemption from control of cannabidiol is because it does not satisfy the criteria for control under either the 1961 Convention or the 1971 Convention. As it does not satisfy the 1961 criteria it cannot be considered narcotic.

This exemption refers only to international control. Should the recommendation be accepted, its implementation will not prevent any country from controlling cannabidiol or cannabidiol preparations.

Japan

The 1961 Single Convention allows for control of a substance if the substance is convertible into a drug (Article 3 para 3(iii)). The Commentary to the Convention makes it clear that the method of conversion should not just be a theoretical one, but must be such that it can be performed “with relative ease” (paras 10 and 11, pp. 88-89) and that the method “must be of such a kind as to make it, by the ease of the process and by the yield, practicable and profitable for a clandestine manufacturer to transform the substance in question into controlled drugs” (para 13, p. 89).

None of the available methods, including the 2008 patented method, could be considered to convert CBD to THC with relative ease. It is also highly unlikely that this would be considered a practicable method for drug traffickers and nor would it be profitable considering the low costs of producing high THC products from the cannabis plant.

Russian Federation

The 1961 Single Convention allows for control of a substance if the substance is convertible into a drug (Article 3 para 3(iii)). The Commentary to the Convention makes it clear that the method of conversion should not just be a theoretical one, but must be such that it can be performed “with relative ease” (paras 10 and 11, pp. 88-89) and that the method “must be of such a kind as to make it, by the ease of the process and by the yield, practicable and profitable for a clandestine manufacturer to transform the substance in question into controlled drugs” (para 13, p. 89).

None of the available methods, including the 2008 patented method, could be considered to convert CBD to THC with relative ease. It is also highly unlikely that this would be considered a practicable method for drug traffickers and nor would it be profitable considering the low costs of producing high THC products from the cannabis plant.

United States

1) The amount of THC in synthetically produced cannabidiol will be extremely small. If the recommendation to exclude from control preparations of cannabidiol containing not more than

0.2% of THC is adopted, then these products will be exempt from control. It is not clear how the recommendations relating to the transfer of THC to the schedules of the 1961 Convention would affect this.

2) The entry in Schedule II of the 1971 Convention for dronabinol is as follows:

DRONABINOL	<i>delta</i> -9-tetrahydro-cannabinol and its stereochemical variants	(6 <i>aR</i> ,10 <i>aR</i>)-6 <i>a</i> ,7,8,10 <i>a</i> -tetrahydro-6,6,9-trimethyl-3-pentyl-6 <i>H</i> -dibenzo[<i>b,d</i>]pyran-1-ol
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The chemically identified substance is present in the cannabis plant and is produced synthetically. The description does not allow identification or differentiation of the source of the substance.

3) Similar to dronabinol, cannabidiol is identified according to its chemical structure which does not differ between plant and synthetic sources. The exemption for cannabidiol would therefore include the substance obtained from the plant and that which is produced synthetically.

4) The ECDD considered and was advised that the exemption specified in the footnote would exempt cannabidiol preparations from control under the 1961 Convention in a similar way that dextromethorphan and dextrorphan are exempt from control based on their respective footnotes.

The ECDD based its recommendation on evidence concerning the lack of abuse and dependence potential of cannabidiol generally and of cannabidiol preparations containing 0.15% delta-9-THC. Consideration was also given to requests from Member States for guidance on appropriate levels of delta-9-THC allowed in cannabidiol preparations. The specified level relates to that used for international control purposes. Member States may be able to use different control criteria for internal country purposes.

5) Based on the recommendations, a preparation containing predominantly CBD but less than the specified amount of THC is not controlled. If the THC threshold is exceeded then that preparation is controlled, but this does not mean that CBD as a substance is controlled, only those preparations that contain THC above the threshold amount.

5.6 Pharmaceutical Preparations of Cannabis and delta-9-tetrahydrocannabinol (dronabinol)

China

1) Based on conventional usage of the term, pharmaceutical preparations are those that are used for defined medical purposes and therefore that are in dosage forms appropriate for such medical use. These pharmaceutical preparations encompass the ones requiring pre-market approval and the ones produced extemporaneously according to a prescription and to agreed good manufacturing practices. The recommendation applies to pharmaceutical products that can include preparations other than those mentioned in the question. It was considered that individual Member States will have their own criteria for assessing whether a product is for medical use and as addressed in their national legislation.

The Committee considered that it was not necessary to recommend a maximum content of dronabinol, as dronabinol would not be recoverable. By comparison, almost all the substances in Schedule III currently (with opium as an exception) are readily recoverable.

2) The only other controlled cannabinoids (excluding the synthetic cannabinoids controlled under Schedule II of the 1971 Convention such as AB-CHMINACA and 5F-APINACA) are the isomers of THC that are controlled under Schedule I of the 1971 Convention. These do not occur naturally in the cannabis plant (one may occur at very low concentrations, but this is not yet certain).

European Union

In reaching its recommendation, the Committee applied the criteria for control of preparations under Schedule III of the 1961 Convention as set out in Article 3 para 4. Neither the availability of a medicine nor the amount of its use form part of the criteria that should be used to determine the suitability of a preparation for inclusion in Schedule III and were therefore not considered by the ECDD.