

B. Questions to INCB

5.0 General questions

China

- 1) Under the impact of recreational cannabis legalization on global drug control, is the current global situation of adolescents using cannabis under control? How can we effectively prevent teenagers from using drugs, especially cannabis? What are the WHO and INCB positions and recommendations?

The Board devoted Chapter I of its 2018 Annual Report to this matter.

“Cannabis and cannabinoids for medical, scientific and “recreational” use: risks and benefits”

https://www.incb.org/documents/Publications/AnnualReports/AR2018/Annual_Report_Chapters/03_Chapter_I_Annual_Report_2018_E_.pdf

- 2) How do WHO and INCB determine that rescheduling Cannabis in the international drug control conventions could reduce cannabis abuse? Is there any research and evidence to prove its effectiveness?

The Board has no role in the scheduling process and therefore cannot address this question.

- 3) As in some of those countries with recreational cannabis legalization, the number of adolescents who abuse cannabis or synthetic cannabis has not decreased, and cannabis price in the illegal market being lower than the legal one in some of those countries. For this situation, what opinion and countermeasures do WHO and INCB have?

We refer again to the Board analysis contained in Chapter I of 2018 Annual Report.

- 4) In response to the recreational cannabis legalization in some countries, a large number of cannabis products, such as candy, cakes, etc., contain high level of THC than cannabis. How would WHO and INCB respond to the possible health problems and medical burden caused by the addiction?

The Board has no authority or resources to respond to the health consequences of a possible increase in cannabis use. The Board will continue to remind countries that Article 38 of the Single Convention of 1961 underscores the importance of measures to prevent and treat drug dependence. This article, as amended by the 1972 Protocol, and Article 20 of the Convention on Psychotropic Substances of 1971 states that “The Parties shall give special

attention to and take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved and shall co-ordinate their efforts to these ends.” Further, the conventions also state that “Parties shall as far as possible promote the training of personnel in the treatment, after-care, rehabilitation and social reintegration of abusers of psychotropic substances” as well as “assist persons whose work so requires to gain an understanding of the problems of abuse of drugs”.

Nigeria

- 1) What will the INCB do differently that will improve its efficiency in fulfilling its mandate under the drug control Conventions?

The INCB will need to monitor the global cultivation, manufacture, trade and consumption as it is the case for all controlled substances. The INCB will also have to ensure a balance between supply of and demand for cannabis raw material and cannabis derivatives to ensure availability for medical and scientific purposes but also to avoid, as prescribed by the conventions, the accumulation of quantities in excess of those required for the normal conduct of business, having regard the prevailing market conditions.

- 2) Is the INCB worried that WHO made the recommendation despite the INCB 2018 Report stating that cannabis is not the first line of treatment and could be replaced by other non-psychoactive substances?

In Chapter I of its 2018 Annual Report the Board stated that recent reviews of the evidence from clinical trials indicate that: (a) there is weak evidence that dronabinol may be useful in treating nausea and vomiting in cancer patients; (b) there is moderate evidence that nabiximols may be useful in treating neuropathic pain and muscle spasticity in patients with multiple sclerosis; and (c) there is moderate evidence that CBD may reduce seizure frequency in some genetic intractable childhood epilepsy syndromes. Cannabinoids are not a first-line treatment for any of those conditions. The INCB has urged in the past all Governments that have established programmes for the use of cannabis for medical purposes to ensure that the prescription of cannabis for medical use is performed with competent medical knowledge and supervision and that prescription practice is based on available scientific evidence and consideration of potential side effects. There is a large variety of cannabis-based preparations in various regions of the world, with different dosage forms, concentrations of psychoactive ingredients, for the alleviation of a wide range of symptoms, using different routes of administration. If the symptoms of certain clinical conditions may be relieved by treatment with cannabis derivatives, it is important for countries to carefully establish the therapeutic value of such treatment through the collection of concrete evidence, and to clearly establish the active principles and the dosages to be used.

- 3) If the INCB has faced serious challenges of persistent abuse of cannabis under the current control regime, is there any guarantee that the recommendation will not further aggravate the bad situation?

We refer again to the Chapter I of its 2018 Annual Report.

“Cannabis and cannabinoids for medical, scientific and “recreational” use: risks and benefits”

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5.3 Tetrahydrocannabinol (isomers of THC)

United States

- 1) Currently, cannabis plants cultivated for industrial purposes are not controlled under the Single Convention. The WHO/ECDD’s recommendation to add THC to the 1961 Convention schedule does not address whether the intent is to overcome this exemption. We are concerned that by adding THC to the 1961 schedule, without some explanation addressing this issue, implementation of the Single Convention would be subject to inconsistent interpretation and application. Considering that many governments are looking at regulating CBD production, this confusion would come at a most inopportune time. Would either the WHO/ECDD or the INCB have language to offer that might clarify this issue?

According to article 28 of the 1961 Convention, States parties may permit the cultivation of cannabis for authorized medical and scientific purposes. Parties that permit such cultivation have an obligation to establish control measures in accordance with the Convention. In addition, the 1961 Convention limits the cultivation of cannabis for industrial purposes to fibre and seed. The cultivation of cannabis for the extraction of CBD would need to be monitored under the provisions of the 1961 Convention because it does not meet the definition of article 28 (2) as the cultivation cannot be considered as being “for industrial purposes” as specified in the 1961 Convention. Also, cannabis cultivated for the extraction of CBD would have some THC content and this would have to be controlled in accordance with its scheduling. As a way of reference, the Board has asked countries cultivating opium poppy variety rich in noscapine (an alkaloid not under international control) to report cultivation of that variety because of the presence of morphine content in that variety.

5.5 Cannabidiol Preparations

United States

- 1) The WHO has stated that CBD is not controlled, if the CBD is produced synthetically or if it is derived from cannabis plants produced for industrial or horticultural purposes. 1) It is our understanding that synthetically produced CBD will contain some quantity of synthetic THC,

currently controlled under the 1971 Convention. By moving THC to the 1961 Convention, does this distinction disappear? Does the INCB agree that synthetically produced CBD is not currently controlled?

The INCB is not given any formal role under the procedure outline in article 3 of the Single Convention but it must give effects to the decision of the Commission in the performance of its treaty function.

- 2) As explained by the WHO/ECDD, the intent of its recommendation to add a footnote was to address the scientific finding and conclusion related to cannabidiol: specifically that CBD does not have psychoactive properties, is not liable to abuse, and does have medical utility. Under these circumstances, we agree that control of CBD under the Single Convention would not appear to be consistent with the aims of the Convention; however, we have questions concerning the WHO/ECDD's interpretation of the Single Convention, as it applies to preparations containing cannabis or cannabis resin. Under the Single Convention, "cannabis" and "cannabis resin" are both a "drug." Furthermore, the Single Convention defines "preparation" as a mixture, solid or liquid, containing a drug, "whether natural or synthetic." Given the definition(s) above, it would appear that preparations containing cannabis or cannabis resin, while not specifically mentioned in the schedules, are in fact subject to the controls of schedule I of the Single Convention. It would be helpful if the INCB could share their view of this provision.

Again, the INCB is not given any formal role under the procedure outline in article 3 of the Single Convention but it must give effects to the decision of the Commission in the performance of its treaty function.

- 3) Would the INCB agree that based on the above, if preparations containing naturally derived cannabis are already subject to the controls of the Single Convention, it is not necessary to schedule THC separately under the Single Convention for naturally occurring THC to be controlled? This would include preparations such as butane hash oils, where butane is used to extract cannabis resin from the plant.

Again, the INCB is not given any formal role under the procedure outline in article 3 of the Single Convention but it must give effects to the decision of the Commission in the performance of its treaty function.