Third and Final CND Meeting on Cannabis-Related Recommendations
Statement of the United States America

Mr. Chair, distinguished participants, dear colleagues,

For the last two years we have struggled to decide what to do with the cannabis recommendations that the World Health Organization forwarded to the Commission on Narcotic Drugs. We have asked for more clarity, repeatedly turned to the Secretariats of WHO, the INCB, and UNODC for assistance, sought guidance from our own experts, listened to the experts of others, and met and exchanged views along the corridors of the VIC, until COVID-19 sent us home. The time is soon approaching when we will need to cast our votes. We cannot delay further, and we should seek to streamline our processes, including by considering the Chair's voting proposal.

On the issues, we understand that two distinct camps seem to have emerged: those whose national policies favor more restrictive drug control approaches, and those favoring more relaxed controls. This division is an artificial one, and an unhelpful one. For the most part, the recommendations before us are not about the measures of control. If we adopt recommendation 5.1, for example, Member States, the INCB and UNODC have confirmed that there would be no impact on the measures of control applicable to cannabis, which are set forth in schedule I. Cannabis has been in Schedule I since the Single Convention entered into force, and following a scientific review and assessment which found that cannabis is a dangerous drug and liable to significant abuse, the WHO has recommended that cannabis warrants continued placement under the strictest measures of control available to the Commission, in Schedule I.

Recall that only a few years ago we had before us a WHO recommendation to place carfentanil in schedule IV. Why did we do that? Because the therapeutic value of carfentanil had changed – through research, drugs had been developed with similar medical utility but without the harmful effects. As provided in the Single Convention, if a substance is particularly liable to abuse and to produce ill effects, and that liability is not offset by substantial therapeutic advantages not possessed by substances other than drugs in schedule IV, then a

substance may be placed in schedule IV. Carfentanil was such a subject. It follows that when the WHO finds that a drug in Schedule IV has substantial therapeutic advantages not possessed by drugs not in schedule IV, the substance should be removed from schedule IV. And this is the case of cannabis, and cannabis resin.

Earlier this week, the United States was pleased to share the expertise of Dr. Volkow, the pre-eminent global expert on drugs of abuse, who oversees the National Institute on Drug Abuse, one of the most prolific contributors to research in the field of cannabis. Dr. Volkow explained that we have approved one cannabis-derived drug product: Epidiolex (cannabidiol), and three synthetic cannabis-related drug products: Marinol (dronabinol), Syndros (dronabinol), and Cesamet (nabilone) for the treatment of a variety of medical conditions. One of these drugs is a safe and effective treatment for a rare form of epilepsy, occurring in children, for which there is no other known drug therapy. This newfound therapeutic usefulness, which is not possessed by other substances, warrants the removal of cannabis from Schedule IV. Nonetheless, we heard some voices ask why? Why should we remove cannabis from schedule IV? And here, the answer is fairly straight forward: because that is our responsibility under the Single Convention. Our purpose in the CND is to use the scheduling process so that drugs indispensable for the relief from pain and suffering are made available globally, but are also subject to effective measures to prevent their abuse and diversion. We have a duty to ensure that the international scheduling of cannabis and cannabis resin accurately reflect the state of the science. Dr. Volkow very clearly outlined an additional reason for "why" we should move cannabis and cannabis resin out of schedule IV – to stimulate research. Now, more than any time in the history of the Commission, there is a critical need for cannabis research. The United States understands that there is increasing interest in the potential utility of cannabis for a variety of medical conditions, as well as research on the potential adverse health effects from use of cannabis. We recognize the critical need to develop therapies for patients, but this will only happen with quality research. The United States supports sound, scientifically-based research into the medicinal uses of drug products containing cannabis or cannabis-derived compounds. Research is underway to assess the therapeutic potential of cannabinoids to treat a variety of health conditions including pain, inflammation, posttraumatic stress disorder, cancer, HIV, digestive disorders, and substance use

disorders. Such research is essential if we are to fully understand the therapeutic potential of cannabis and cannabis preparations and make safe, effective, quality products available to our citizens.

There are those who expressed concerns that any change in status would lead to an increase in cannabis abuse. But we heard from several experts on Tuesday that cannabis is the most widely abused drug in the world with approximately 192 million users world wide. The rates of cannabis consumption have climbed steadily since the 1990 UNGASS. During this entire period, cannabis and cannabis resin have been in schedule IV. As the expert from Colombia so wisely observed, the status or stigma of being in schedule IV did not prevent the dramatic escalation of cannabis use, and it is unlikely that removing it will lead to any increase. On the contrary, to those who are skeptical of warnings that cannabis abuse can be harmful - and here we know that youth are particularly doubtful - keeping cannabis and cannabis resin in schedule IV despite scientific evidence will signal that the Commission is tone deaf, and out of touch, and they will ask why? Why do we need a CND or a scheduling process if all they do is make drugs even less accessible to those in pain or suffering. And while we know that the status of being in schedule IV does not impose any additional controls on drugs, the WHO and INCB continue to report that some countries make controlled substances virtually inaccessible to those in need.

Turning briefly to the other WHO recommendations, we firmly believe that recommendations 5.2, 5.3, 5.5, and 5.6 are outside the scope of the scheduling process. We have previously expressed our reasons for opposing these recommendations but to summarize: if adopted, at best they would introduce legal ambiguities and contradictions which may undermine effective drug control, and at worst, they could result in the exclusion from control of all THC derived from cannabis cultivated for industrial purposes, and THC derived from leaves separated from the cannabis plant. This would undoubtedly lead to further cannabis abuse. With respect to the threshold for THC, we remain convinced that assigning thresholds for criminalization is a decision for each member state, and note many states, including our own, have addressed this. We support recommendation 5.4, the elimination of tinctures and extracts of cannabis from schedule I. We view this as a clarification that will remove an ambiguity and align with current practice by removing redundant language which contributes to misunderstandings.

We also firmly oppose any changes that will increase the financial burdens of member states or the United Nations system.
Regardless of the outcome this December, we are committed to continuing these discussions after the vote to ensure the public is well aware of the health harms of cannabis and its Schedule I status, and that reporting and trade issues are addressed through appropriate CND and INCB action outside the scheduling system.

We thank the Chair for his skilled leadership, and the INCB, UNODC and WHO Secretariats for their tireless efforts to guide us through this maze, and we thank the Government of Japan for its financial support during the but we would be remiss if we did not close with a caution to members of the Commission, that while we can consult with these international bodies, and their input to our deliberations is invaluable, the final responsibility for these decisions rests with us. We are not passive observers of this process, we are the policymaking body of the UN system with prime responsibility for drug-related matters. We do not need to be afraid of the message this recommendation may or may not send; the world is looking to us for leadership and it is within our power to ensure this recommendation is adopted in a way that sends a constructive message, based on science, that protects public health.