dianova

Position Paper on Addiction and Cannabis Policies

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Dianova & the Addictions

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General Views

Addiction is characterized by a person's inability to stop a repeated cycle of behaviours aimed at providing pleasurable feelings or at reducing discomfort, and the persistence of such behaviours despite harmful consequence (health and financial problems, isolation, loss of employment, etc.)

The concept of addiction not only refers to licit or illicit psychoactive substances. Addictive disorders may also be triggered by such compulsive behaviours as pathological gambling, addiction to sex or pornography addiction, or Internet-related addiction.

IS ADDICTION A DISEASE?

Dianova adheres to the definition of addiction proposed in 2019 by the *American Society of Addiction Medicine* (revision of the 2011 definition): “Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviours that become compulsive and often continue despite harmful consequences”. "According to this model, people with substance use disorders or other addiction need similar level of care as people with other medical conditions.

Dianova believes that this view of addiction as one pathology among others helps to reduce the stigmatization of people with substance use disorders or other addictions. On the other hand, in Dianova’s opinion, the explanatory model of “addiction as a disease” should not overshadow the multifactorial nature of the problem (see below: *vulnerability and protection factors*). Similarly, although advances in neurobiology and brain imaging make it possible to take a fresh look at the problem and develop promising treatments, they should not call into question the value of biopsychosocial approaches in the treatment of addiction.

VULNERABILITY AND PROTECTION FACTORS

Addiction is a multifactorial problem, which means that a set of factors (associated with each other and not taken separately) constitute **a vulnerability to the onset of an addictive disorder**. These factors are of four types:

- *Factors associated with substances or behaviours:* toxicity and neurotoxicity (short or long term), physiological and psychological addictive potential (the ability of a given substance to produce dependence).
- *Individual factors:* genetic and neurobiological factors, temperament and personality traits ('sensation-seeking', 'boredom proneness’, 'novelty seeking'), lack of interest in school or school dropout, disturbance of emotional responsiveness, mood disorders, anxiety disorders and other psychiatric disorders, early age of initiation to drug use, positive first experiences.
- *Factors related to the living environment:* unstable social situation, poor housing, stressful life events, poor working conditions and stress ; within the family: lack of reference person, conflicts, inconsistent rules, neglect or abuse, parents' attitudes towards substances,

substance use by parents or siblings, and early exposure to substance use; in the circle of friends: peer pressure.

- *Environmental factors:* socio-cultural factors (immigration, acculturation, marginalisation), permissive norms, valuation of certain consumption patterns, policies or legislation, availability and accessibility of substances, exposure to advertising and marketing (cannabis, alcohol, gambling, etc.); lack of leisure facilities, disintegration of neighbourhoods.

Protective factors are those factors which **contribute to reducing the likelihood of people developing addictive disorders**; they may also stimulate people's ability to adapt to stress and personal difficulties.

- *Individual factors:* positive temperament, problem-solving ability, self-efficacy, using one's own resources while being able to seek external help, self-esteem, self-confidence, self-reliance, resilience (development process despite difficult circumstances).
- *Factors related to the living environment:* good parent/child relationship, presence of a peer helper or adult role model, positive family environment, adequate social skills; at work: good work environment and quality of life, support from colleagues and hierarchy.
- *Environmental factors:* good social integration, sense of usefulness to the community, sense of belonging to the community and adherence to its values.

Addiction Prevention among Young People

Adolescence is most often characterised by a period of integration into the circle of friends and a distancing from parents. It is also a phase of curiosity, risk-taking and challenge. For many, it is also the age of initiation of legal and illegal psychoactive substances, including alcohol, tobacco or cannabis.

SOCIAL AND HEALTH RISKS

At this age (as in intrauterine life and childhood), the brain is very sensitive to stress and psychoactive substances. Research has shown that in adolescence, the brain is in a unique state of transition and shaping that makes it more vulnerable to the neurotoxic effects of substances and the onset of mental illness.

Regular use of alcohol, tobacco and cannabis during adolescence is associated with a wide range of health and social consequences, both short and long-term (when reaching adulthood):

- **Alcohol** - short term: risk of alcoholic coma, interpersonal violence, unwanted sexual relations and pregnancies, traffic accidents; long term: gastrointestinal diseases, cardiovascular diseases, cancer, chronic alcoholism or addiction.
- **Tobacco** - regular consumption often marks the beginning of long-term use, associated with long-term health damage: addiction, cancers (lungs, upper aero digestive tract), chronic bronchitis, cardiovascular disease, etc.

- **Cannabis** - short and medium term: *see below*; long term: health consequences similar to those associated with tobacco.

Cannabis and mental health

Despite being less dangerous than other substances, cannabis is far from being harmless. **In adolescence, frequent and regular use can in particular harm the development of the brain,** especially for those who start using at an early age. Studies report cognitive difficulties related to memory, concentration, and literacy and numeracy skills. People who use cannabis are also more likely to have difficulties or experience school failure than those who do not use it.

Several studies have linked **regular cannabis use to increased risk for psychiatric symptoms or disorders** (e.g. schizophrenia and other psychotic disorders, depressive and anxiety disorders, suicidal thoughts). **The risk of developing a mental health disorder increases particularly among people who started using in adolescence** and among users with a personal or family psychiatric history. Daily use is associated with a greater frequency of these mental illnesses in adulthood, including schizophrenia. On the other hand, it should be noted that the link between cannabis use and mental health disorders does not imply that cannabis is the direct or sole cause.

Behavioural addictions can also have detrimental consequences for adolescents. Gambling for example, which is a popular and prevalent behaviour among adolescents, may lead to a loss of control, a greater propensity to use substances, depressive symptoms, suicidal risk, financial losses, reduced school performance, crimes and offences, etc.

IMPORTANCE OF EARLY PREVENTION

The prevention of addictive disorders in adolescence is a major challenge for society as a whole. However, prevention activities are often poorly designed and, more often than not, grounded in beliefs and ideologies rather than scientific evidence. Moreover, these activities usually lack consistency, both in terms of lines of intervention and funding, and are not adapted to the specific characteristics of their target groups.

Dianova believes that addiction prevention among young people must integrate societal changes (new drugs, new consumption patterns, changes in legislation, etc.) and use science-based intervention strategies relying on a set of standards and methodological guides. These strategies are based on:

- The acquisition of psychosocial skills (problem solving, decision-making, interpersonal skills, stress management, etc.).
- Interventions aimed at developing parenting skills (communication skills, conflict management, ability to set limits, etc.).
- Prevention strategies tailored to vulnerable young people (e.g. those whose parents suffer from substance use disorders)

The different types of prevention strategies

Universal: approaches designed for an entire population without regard to individual or collective risk factors.

Selective: approaches targeting subsets of the population that are considered at-risk for substance use and addiction

Indicated: interventions targeting those already using or engaged in other high-risk behaviours to prevent heavy or chronic use

In this regard, **Dianova recommends the development of comprehensive, early prevention strategies** involving not only the target audience (e.g. students at school), but also parents and community stakeholders. Such programmes should include not only in-school modalities (e.g. development of psychosocial skills), but also out-of-school modalities, such as programmes targeting parents, while at the same time ensuring that young people are provided with broad and worthy public spaces for leisure and healthy recreation.

Finally, it is essential that programmes be not only **flexible and diverse, but also adapted to the characteristics of the target population**. In particular, the design and implementation of these programmes must be based on a **gender perspective**, i.e. capable of responding to gender-differentiated needs, and taking into account the differences between men and women or boys and girls, both in terms of consumption behaviours and social representations, or, for younger people, the psychological or physical development during adolescence.

Dianova: Respect for Human Rights and Autonomy

Addiction leads to a considerable loss of autonomy; nevertheless, the people concerned are still capable of making a number of choices with regard to their substance use (achieve abstinence, cut down, switch to substitution treatment, etc.), and their expectations of treatment.

Dianova's approach therefore recognises people's ability to decide for themselves, change their practices, and choose what seems to be best for their own health and quality of life. This approach is based on fundamental human rights and on the principles of respect for the individual, human dignity and the protection of people in vulnerable situations. This is why any intervention, whatever it may be, implies a duty to create a caring, safe and supportive environment for people with addictive disorders, while respecting their expectations and needs.

CONCEPT OF GREATEST POSSIBLE LEVEL OF SELF-RELIANCE

When a person enters one of our programmes, we must first limit ourselves to listening to their suffering and distress. We cannot try to implement an optimal and definitive solution right away. We must instead accompany them through a process of risk limitation with regard to their substance use or other addictive behaviour. We must seek to understand what may cause or trigger these problems.

This is why Dianova's addiction counsellors do not seek to impose a single treatment goal for all – for example abstinence from substance use – but rather to adapt these objectives to each person's expectations, abilities, social situation and personal history. This approach also implies to consider the ambivalence that many people feel, especially at the beginning of treatment. Within this framework, **Dianova's counsellors endeavour to lead people, with their active participation, to the greatest possible level of self-reliance***,* so that they become able to make responsible and informed choices about their use of substances or other addictive behaviours.

MAINSTREAMING A GENDER PERSPECTIVE

Men and women are physiologically unequal as regards their use of substances, but they are also unequal in terms of social representations and expectations: men use more substances and more often than women, but society takes a much harder line on women who use drugs. This social sanction has concrete consequences: less social and family support, financial insecurity, social isolation, obstacles to accessing services and invisibility of the problem.

The gender-sensitive perspective is a comprehensive analytical framework that enables an analysis of the current situation. It analyses the cultural and social constructs that have historically been attributed to the masculine and feminine notions, and therefore, what is considered masculine and feminine.

Addressing substance use disorders from a gender-sensitive perspective implies to consider gender differences and specificities as factors that may condition the motivations to use drugs and the various consumption patterns, as well as their social and health consequences. It further entails eliminating the disadvantages or inequalities that women face in women's access or adherence to treatment or prevention programmes or services.

Gender equality is a fundamental right, which is why Dianova believes it is essential to mainstream the gender perspective into the DNA of organizations, programmes and services dedicated to treating substance use disorders and other addictions.

It is especially critical to adopt positive measures around some of the starting points of women's social disadvantage, and to carry out specific actions for specific needs, for both men and women. These measures must be based on a comprehensive reflection process, prior training of professionals (counsellors and programme managers), as well as adequate and effective programme design.

INTERSECTIONALITY

In order to respond adequately to the needs of different groups and populations (LGBTQI+, homeless people, people with disabilities, migrants and refugees, etc.), **Dianova believes it is useful to use an intersectional analysis framework**, based on the principle that social differentiations such as gender, ethnicity, class or sexual orientation are not compartmentalized and should therefore be analysed based on their multiple mutual influences.

The International Drug Control System

The international drug control regime was first implemented more than a century ago with the signing of the first international conventions. At the time, these conventions were primarily aimed at controlling the unregulated drug market rather than prohibiting it. Subsequently, the United States began advocating increasingly restrictive international measures based on the prohibition and criminalization of the use, trade and production of the plants used in the production of narcotics, except for scientific and medical purposes.

Over the past fifty years, the pillars of the international drug control system have been embodied in three international conventions adopted by the United Nations member states:

- ***The 1961 Convention on Narcotic Drugs,*** also called *Single Convention*, which combines previous legislation and constitutes the legal basis of the regime.
- ***The Convention on Psychotropic Substances of 1971*** on the control of psychoactive substances.
- ***The Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988,*** aimed at strengthening cooperation among the international community in order to combat drug-related problems.

CHALLENGING THE SYSTEM

The negative consequences of a regime based mainly on prohibition are being voiced by a growing number of governments, NGOs and international agencies. The same argue that this regime has proven ineffective in containing supply and demand. Moreover, prohibition has also stimulated the growth of the global illicit drug trade.

As a result of a thriving black market, funds initially allocated to public health have been redirected towards funding law enforcement. This shift blatantly contradicts one of the goals stated in the Preamble of the 1961 Single Convention: *"The parties, concerned with the physical and moral health of mankind (...)".* As the United Nations Office on Drugs and Crime, the main UN body involved in drug control, acknowledged it itself in its 2008 report: *"Public safety has taken the place of public health as the first principle of drug control."*

The 2011 report of *Global Commission on Drug Policy* paints a daunting picture of the current situation. As noted in the report, the public safety and repression approach has resulted in extravagantly high public spending and devastating health consequence. In addition, this approach has utterly failed to curb drug trafficking and organized crime, created obstacles to development in producing nations, and generated multiple human rights violations, stigmatization of people who use drugs, pollution and deforestation, etc.

Finally, it should be emphasized that in spite of these policies, drug use around the world has been on the rise, in terms of both overall numbers and the proportion of the world's population that uses drugs.

In 2009, the estimated 210 million users represented 4.8 per cent of global population aged 15–64, compared with the estimated 269 million users in 2018, or 5.3 per cent of the population[1].

THE RECOMMENDATIONS OF DIANOVA

The international drug control system lays the foundation for most of the policies implemented by UN member countries in their objective of bringing "the world drug problem" to an end, with approaches essentially based on prohibition and repression. These approaches have not only failed to achieve their objective of significantly and sustainably reducing the world drug market, but have also had dramatic consequences for public health, security and development, while perpetuating risky forms of substance use and, in a number of countries, punishing people disproportionately.

Despite these failures, however, the efforts of NGOs and other organizations have improved the overall situation of people who use drugs. As a result of these efforts, we have been able to better address the ongoing problem of stigmatization and discrimination, and to persuade authorities to adopt vital public health-based measures and services, including harm reduction policies and adequate treatment and reintegration services.

Dianova believes it is essential to build upon these achievements a continue efforts to review the current international drug control system. It is vital, for example, to end the criminalization of drug users and emphasize a balanced and complementary public health approach, utilising science-based interventions.

A number of treatment and rehabilitation approaches, such as professional therapeutic communities, are part of these methods. Harm reduction policies are effective, low-cost solutions, but they cannot serve all needs. Rehabilitation programmes, both residential and outpatient may seem more costly, however in the longer term they represent cost-effective investments because they help reduce healthcare costs, work absenteeism and crime. This is why Dianova urges governments to implement a complementary set of policies without favouring one approach to the detriment of another.

[1] World Drug Report 2020, United Nations Office on Drugs and Crime

Dianova's Position Statement in the Addiction Field

1) **Dianova notes the limits of an international drug control system centred mainly on prohibition and repression.** The ideal of a drug-free world was credible fifty years ago but does not seem realistic given the data we have today. The inability to stop the increase in trafficking and the consumption of psychoactive substances, especially among young people, shows the need to revise the current approach.

2) **Dianova supports reforming the general framework of United Nations drug conventions and agencies towards a public health approach.** This framework must shift from a primary focus on prohibition and criminalization to a public health approach that respects human rights and utilises medical research to implement effective rehabilitation programmes. The reform should encourage innovation, solutions adapted to a constantly changing problem and enhanced treatment opportunities. Moreover, we expect United Nations agencies to play a leading role in this shift in thinking by encouraging governments to implement a set of appropriate and complementary solutions.

3) **Dianova supports the establishment of major debates on dependencies on a national level.** It is urgent that attitudes towards dependence evolve in each country and, therefore, we support holding interdisciplinary political, scientific and societal debates to formulate recommendations for reducing the damage caused by the use of various substances while taking account the comparative dangerousness of each of these substances.

4) **Dianova advocates decriminalizing the use of all psychoactive substances, within the limits established by law.** Hundreds of thousands of people with substance use disorders are prosecuted and punished with long prison sentences, and may be executed in some countries, for having used illegal drugs. Even democratic states impose the burden of criminal records upon users which denies them certain rights and access to jobs. Dianova supports implementing policies based upon public health and human rights and calls for ending ineffective and repressive policies that serve only to marginalize people who use drugs and reduce their access to the care that they need.

5) **Dianova supports the implementation of measures based on scientific data and evidence.** We must limit the influence of ideologies and subjective representations. We must instead promote approaches and programmes that are validated by scientific data and regularly monitored and evaluated.

6) **Dianova supports the implementation of complementary measures and innovative alternatives to prevent and treat addiction.** Focusing on a single approach or category of programme (e.g., residential/outpatient treatment or harm reduction strategies) cannot meet all of the specific needs of people with substance use disorders. Dianova, therefore, supports implementing a holistic approach based upon the needs of individuals and their fundamental rights.

7) **Dianova supports universal patient access to essential medicines and pain relief.** The international drug control system does not provide equitable access to medicines such as opioid analgesics, which are essential for managing pain and suffering. Access to pain control medicines is a fundamental human right and Dianova calls for the elimination of all political obstacles that

prevent some low- and middle-income states from ensuring adequate supplies of these medicines.

8) **With regard to cannabis, Dianova defends each country's right to implement legal regimes adapted to their situation and respectful of human rights.** Cannabis is one of the most widely used substances worldwide and each country faces specific problems in this regard. Dianova believes that the international drug control system should allow all countries to regulate cannabis use based on legal regimes adapted to their needs and respectful of individual rights and interests. In the case of countries having opted for legalization, Dianova advocates the implementation of strict regulatory policies grounded on efficient control measures *(see section: Legality of Cannabis).*

9) **Dianova opposes the legalization of any other internationally controlled psychoactive substance.** Reducing the consumption of frequently used substances such as tobacco, alcohol and cannabis, and preventing their use by minors is already a very difficult task for governments. For this reason and in the light of current knowledge, Dianova believes that legalizing these substances could lead to a drastic increase in their consumption with serious consequences for public health.

Legality of Cannabis

Cannabis is by far the most widely cultivated and consumed illicit drug worldwide, despite international treaties that restrict its use to medical and scientific purposes. It is also the drug that has been most subject to repressive efforts since its inclusion in the international drug control system.

BRIEF HISTORY OF INTERNATIONAL CONVENTIONS

Cannabis is classified alongside cocaine and heroin in the Single Convention (see section: *International drug control system*). These treaties were drafted and negotiated at a radically different time, when drug-related issues were only a marginal concern for most countries, which led a small number of these countries to steer the development of the international control system in their chosen direction: prohibition.

It is now established that some key individuals and the most activist delegations in the international drug control bureaucracy were able to favour certain sensationalist research findings in order to impose cannabis as a particularly dangerous substance, which should therefore be subject to the strictest multilateral control.

These conclusions, now discredited, were based on views that were racist oftentimes and alleged preposterous links between cannabis use and insanity, crime, or moral decline, or its role as a gateway to 'hard drugs'. This was more than enough to demonise cannabis and the people who use it.

THE FAILURE OF REPRESSION

After fifty years of prohibition and repression, the results are overwhelming. Prohibition has proved ineffective in reducing the spread of the illicit market or the health damage caused by cannabis. Conversely, cannabis prohibition imposes heavy burdens on criminal justice systems, leads to adverse public health consequences and creates criminal markets that only reinforce organised crime, violence and corruption.

Moreover, the criminalization of people who use cannabis can have devastating consequences for their lives: imprisonment, revocation of a professional licence, denial of access to public jobs, etc. Finally, prohibitionist policies promote the stigmatisation and discrimination of people who use cannabis and make their access to treatment more difficult.

Some definitions

Decriminalization: this involves no longer considering the use or possession of small quantities of cannabis as an offence punishable by a prison sentence. Nevertheless, even when decriminalized, cannabis remains illegal: traffickers remain prosecuted and cannabis users may be subject to minor penalties.

Legalisation: it means to make legal the consumption, distribution, ownership and sale of cannabis, when they were previously illicit. Cannabis legalisation can be carried out in an open market, simply governed by supply and demand and with little or no state intervention, or it can be state-controlled via a regulatory strategy.

Regulation: a complementary process to legalisation, regulation is defined as compliance, under state control, with a number of obligations and prohibitions covering the entire value chain of the substance, including its cultivation, production, distribution, sale and consumption (e.g. prohibition of sale to minors and of advertising, restricted sale to certain places, production licences, register of people who use, price controls, etc.). Depending on the legislation, the levels of regulation can vary widely

MOVEMENTS AGAINST PROHIBITION

The status of cannabis in the international drug control system has long been disputed. The movement began as early as the 1970s; while the United States was on the brink of its 'war on drugs', several of its states officially decriminalized the possession of cannabis for personal use. At the same time, the Netherlands re-evaluated its cannabis policy, leading to the development of coffee shops, a system that has been repeatedly criticised by the International Narcotics Control Board (INCB) as exceeding the limits of the Conventions.

At present, the movement is intensifying in favour not only of decriminalization, but also of legalisation of cannabis, through varying degrees of regulation. As of October 2020, the recreational use of cannabis has been decriminalized in several countries of the American continent and the European Union, and it has been legalised and regulated in Uruguay, South Africa, Georgia and 11 states of the USA. Worldwide, the trend towards decriminalization and even controlled legalisation of the recreational use of cannabis is definitely on the rise.

International treaties give nations a certain amount of latitude with respect to the decriminalization for personal use or therapeutic purposes, or the provision of harm and risk reduction services. Nevertheless, some 'red lines' should not be crossed, and giving people a legal access to recreational cannabis use, as well as for the 250 other substances under international control, is clearly out of bounds.

In order to address discrepancies between the international drug control system and the worldwide trend, we believe that civil society organizations and other stakeholders should assume a leadership role and make their opinions known so as to shed more light on this issue.

THE MEDICAL USE OF CANNABIS

A cannabis plant contains more than 500 chemical compounds of which about 100 are cannabinoids, which is why its therapeutic applications are very difficult to classify and study.

Despite these difficulties, the therapeutic use of cannabis is increasingly accepted, and even legal in many countries. At present, many patients report that cannabis use has proved effective in relieving a number of symptoms (see framed text). However, despite this popularity, the evidence remains anecdotal and **research has yet to validate the medical benefits of cannabis.** This is due to two main reasons: firstly because research studies are methodologically difficult to implement, and secondly because many scientists are discouraged by the regulatory burden imposed on them by the restrictive laws still in force in many countries and derived from the classification of cannabis in the international drug control system.

CBD, THC and forms of therapeutic cannabis

The two main cannabinoids that may be used for therapeutic purposes are tetrahydrocannabinol (THC) and cannabidiol (CBD). THC is the psychoactive ingredient in cannabis while CBD has no such properties. Cannabinoid drugs may be helpful in treating **certain forms of epilepsy**, chemotherapy-induced **nausea and vomiting**, and **loss of appetite and weight loss** associated with HIV/AIDS. In addition, some evidence suggests modest benefits of cannabinoids for **chronic pain** and **multiple sclerosis** symptoms.

Scientists generally consider medications that use purified chemicals derived from or based on those in the cannabis plant to be of therapeutic interest. However**, they do not recommend the use of the cannabis plant as a medicine** as it poses other problems associated to the hundreds potentially harmful chemicals it contains, in addition to known adverse health effects of smoking and THC-induced cognitive impairment.

Cannabis used for therapeutic purposes can take three main forms:

Pharmaceuticals: synthetic or natural products with standardised ingredients, e.g. *dronabinol* and *nabilone* (synthetic THC), *nabiximol* (50/50 mixture of THC and CBD, natural and chemically pure);

Medical grade cannabis: produced and processed under standardised conditions, without adulterants, high levels of CBD, reduced levels of THC (form: herb, oil, tablets);

Uncontrolled cannabis (illegal or poorly regulated market): THC and CBD levels often unknown, presence of adulterants possible – *use not recommended*

These substances must be submitted for approval to national or regional health authorities, such as the US Food and Drug Administration (FDA) or the European Medicines Agency (EMA). Currently (2020) a cannabidiol solution (Epidyolex®) has been approved by both the FDA and the EMA for the treatment of a severe and rare form of epilepsy.

Dianova's Position Statement on Cannabis Policies

INTERNATIONAL CONVENTIONS

Dianova considers it essential to adapt the international drug control system so that countries can implement legal regimes adapted to their situation and respectful of human rights.

The prohibitionist and repressive cannabis policies still in force in many countries are directly derived from the international drug control system. These policies fail to achieve their objective of reducing demand and only reinforce an illegal market where the health-related impact of cannabis cannot be monitored.

For this reason, Dianova supports the decision taken in December 2020 by the United Nations Commission on Narcotic Drugs to follow the recommendation made by the World Health Organisation to reclassify cannabis and cannabis resin in the international conventions, thus paving the way for easier scientific research on the therapeutic applications of cannabis and cannabinoids -- although this substance remains under international control.

With this landmark decision, the therapeutic interest of cannabis is de facto recognized by the United Nations, thus reflecting the reality of the growing market for cannabis-based medicines. Dianova therefore believes that the United Nations decision is a very important step, but considers it essential to examine the subject matter further in order to reach an international consensus based on scientific evidence.

DECRIMINALIZATION OF RECREATIONAL USE

Dianova advocates the decriminalization of the recreational use of cannabis in all countries as well as limited self-cultivation despite its potential abuses.

Punitive prohibitionist policies against people who use cannabis only serve to reinforce illicit cannabis markets with no interest for public health whatsoever, while adding to the stigmatisation of people who use cannabis and having no positive impact on consumption levels, safety or public health.

Dianova considers it essential that countries in which recreational use is still a crime make the necessary legislative changes toward decriminalization. Dianova also recommends that any fines that may be imposed as a result of decriminalization be replaced by voluntary prevention or treatment sessions.

Dianova recommends decriminalizing cannabis self-cultivation limited to a few plants but stresses that the abuses are potentially numerous and difficult to control. In several countries, various collectives have succeeded in genetically modifying cannabis in order to obtain more annual harvests, as well as a THC level of up to 50%, resulting in higher risks for people who use this substance.

LEGALIZATION OF RECREATIONAL USE

Dianova believes that each country has to face specific problems regarding the recreational use of cannabis, which is a psychotropic substance whose use may cause significant health problems, particularly among children and adolescents. For this reason, **Dianova recommends initiating major national debates involving civil society, the academia, associations of cannabis users, prevention and treatment professionals, and other interested parties, on the various uses of this substance, in order to reach a consensus position.**

Whatever form the legal framework of cannabis recreational use may take – decriminalization or regulation – dianova believes that it should first and foremost ensure that the rights and interests of people who use cannabis are respected, while combating all forms of illicit trafficking.

In the event of legalization, Dianova advocates the implementation of strict regulatory policies grounded on stringent control measures on cultivation, production, transport, and sale, in particular by prohibiting its sale to minors, as well as all forms of advertising or marketing.

In the event of legalisation in an open or poorly regulated market, Dianova believes that there are much greater risks of trivialisation of consumption and a reduction in the perception of risk, particularly through advertising, marketing and the sale of by-products and cannabis-derived substances

THERAPEUTIC USE

Dianova is in favour of the therapeutic use of cannabis provided that it is authorised by health authorities. Dianova also recognises the right of patients to have access to standardised quality products under medical prescription, but recommends that quality studies on the safety and efficacy of therapeutic cannabis be pursued.

The therapeutic applications of cannabis (in particular the CBD and THC cannabinoids) seem quite promising, especially in treating chemotherapy side effects, chronic pain and for its appetite stimulating effects. Nevertheless, the validation of the therapeutic value of cannabis through quality scientific studies has been long hindered by its prohibition in the international drug control system.

Dianova recommends to pursue quality research studies on the therapeutic value of cannabis and cannabinoids and, to this end, approves the reclassification of cannabis in international conventions because it will give researchers easier working conditions.

Despite scientific uncertainty, many patients report that their symptoms have been relieved by the therapeutic use of cannabis, either in the form of herbs, resins, etc. or pharmaceutical specialities. Dianova believes that these patients should be supported and listened to, and that they should be able to access, upon medical prescription, standardized and medical grade quality products (cannabis plant and derivatives, natural and synthetic pharmaceutical products) distributed in pharmacies or specialized centres upon approval by health authorities.

EDUCATION, PREVENTION AND TREATMENT

Whichever legislation model is adopted, Dianova recommends the implementation of a human rights-centred public health policy that promotes recognised education, prevention, and treatment approaches.

Dianova believes that despite their patent advantages, policies based on decriminalization or regulation of recreational and therapeutic cannabis are likely to trivialise its use and thus decrease the perception of risks. For this reason, Dianova believes it is essential to base all policies on a public health approach attentive to the needs of people and respectful of their rights, in particular in the following areas:

In terms of education, Dianova recommends that reliable information be provided in order to reduce the perception of cannabis as a "natural and harmless" substance and to highlight the risks associated with its use, particularly during adolescence.

In terms of prevention, Dianova recommends investing in science-based, diversified programmes, particularly among young people, aimed at preventing the use of cannabis or at least delaying its onset at an age when the risks are lower. These programmes must be tailored to the needs of each population and include a gender-oriented perspective that takes into account the differences between men and women or boys and girls, with regard to consumption patterns and social representations.

In terms of treatment, Dianova also recommends investing in science-based, diversified programmes tailored to each group of people, including the most vulnerable. Treatment networks should consist of recognized modalities including outpatient and residential treatment programmes (e.g. therapeutic communities) and harm reduction approaches.

Overview of the legal status of cannabis use in some of the countries where the Dianova network operates (October 2020)

Uruguay: *recreational use* has been legal since 2013 (first country to legalise), under state control and highly regulated: accessible only to citizens or permanent residents aged 18 and over, previously registered; standardized products available in pharmacies only (9% THC max., 10 g. per week); authorised self-cultivation (6 plants max., harvest 480 g. per year, max.). *Therapeutic use:* legal, under medical prescription.

Portugal: *Recreational use* - drug use remains illegal, but the use/possession of illegal psychoactive substances has been decriminalized since 2000 (without exceeding the individual average quantity of 10 days' consumption); the offence is administrative and sanctioned by *Substance Use Deterrence Committees*. Trafficking and cultivation of cannabis remains a criminal offence. *Therapeutic use* - the prescription of cannabis medications, preparations and substances for medical purposes is permitted on condition that conventional medicines do not produce the expected results or have adverse side effects. Sale is authorized in pharmacies and on medical prescription only.

Nicaragua: *recreational use:* consumption, possession, distribution or transport is considered an offence punishable by imprisonment. *Therapeutic use:* illegal.

Italy: *recreational use*: consumption and possession are decriminalized and considered a mere administrative offence punishable by a fine, with no entry in the criminal record. However, trafficking or transfer, even for free, is a criminal offence. Cultivation and sale of *light cannabis*, i.e. with a THC concentration of between 0.2 and 0.6%, is permitted. *Therapeutic use:* herbal preparations, extracts and tinctures based on cannabis are authorised under medical prescription when conventional or standard therapies have proved ineffective.

United States of America: federal law prohibits the recreational and therapeutic use of cannabis, however various CBD-based derivatives are authorised under medical prescription. At state level, policies vary widely: *recreational use* is legal in 11 states (lightly regulated generally) and decriminalized in 16 additional states. *Therapeutic use* (under medical prescription) is permitted in 33 states, while 14 additional states impose a limit on the THC level of products.

Spain: *recreational use* of cannabis is decriminalized (consumption, possession and cultivation), except for profit and trafficking purposes. *Therapeutic use*: the penal code does not distinguish between therapeutic and recreational use, but in practice this distinction is increasingly taken into account, and patients can obtain, on prescription, cannabis products (CBD) not exceeding 0.2% THC. Note the presence of *cannabis social clubs* (private, not-for-profit) which allow their members to acquire cannabis for therapeutic or recreational purposes (legal situation unclear).

Chile: *recreational use* has been decriminalized since 2016; self-cultivation is authorised in private places for 'personal and close in time use'; consumption in public places is punishable by a fine, community work, suspension of licence or compulsory participation in a prevention programme. *Therapeutic use:* authorised; derivatives available in pharmacies under medical prescription.