CBD is a Human Right — Evidence Brief

Cannabidiol (CBD), patient access and transparent decision-making

Final public website version · v4.1 · 17 June 2026 · Prepared for cbdhumanright.org/evidence

The narrow question

This brief does not ask whether every CBD product is safe, whether CBD treats every condition, or whether CBD can never be converted under laboratory conditions. It asks a narrower policy question: **has government published evidence sufficient to justify treating lawful CBD as a drug precursor and restricting patient access?** On the current public record, the answer is no.

This is health-policy advocacy, not product promotion. The campaign does not sell, recommend or link to any CBD product or brand. It asks governments to decide in the open, on published evidence, and to regulate proportionately.

Quick-read summary

Pure cannabidiol (CBD) is a non-intoxicating cannabinoid. Pure CBD is not scheduled as a narcotic or psychotropic substance under the international drug-control conventions, and the World Health Organization's expert review found no effects in humans indicative of abuse or dependence potential.

The current policy concern is different: whether CBD should be treated as a precursor for the illicit manufacture of intoxicating cannabinoids. That would be a serious step. It should require published evidence of actual use and diversion from lawful CBD channels — suspicious shipments, seizures, clandestine-laboratory evidence, or repeated documented use of lawful CBD as the starting material for illicit manufacture.

The INCB notice is best read as a vigilance and supply-chain signal. It reports large voluntary pre-export notifications of CBD from China and asks national focal points to increase supply-chain knowledge. It does not, by itself, prove that lawful CBD is being diverted at scale. The public record describes the evidence of CBD as the actual starting material as "limited", and the documented Romanian HHC network appeared to obtain CBD on site from industrial hemp / low-THC cannabis rather than from diverted pharmaceutical or compliant consumer CBD.

The proportionate answer is targeted regulation: test and label CBD products; keep medicines, foods, cosmetics, vaping products and illicit intoxicants in their proper legal categories; enforce directly against HHC and other intoxicating synthetic or semi-synthetic cannabinoids; and publish the evidence before any restriction affecting patient access. A covert or blanket precursor restriction would not meet that standard.

Acronyms on first use: INCB — International Narcotics Control Board; CND — Commission on Narcotic Drugs; HHC — hexahydrocannabinol; SSC — semi-synthetic cannabinoid; SCRA — synthetic cannabinoid receptor agonist (the "Spice" family); ACMD — UK Advisory Council on the Misuse of Drugs; EUDA — European Union Drugs Agency; ANSES — French Agency for Food, Environmental and Occupational Health & Safety; ECHA — European Chemicals Agency; SCCS — EU Scientific Committee on Consumer Safety; EMA — European Medicines Agency; EFSA — European Food Safety Authority; CJEU — Court of Justice of the European Union.

Evidence map

Issue	What the evidence supports	Policy implication
Pure CBD and international control	Pure CBD is not internationally scheduled as a narcotic / psychotropic substance; WHO found no abuse or dependence potential in humans.	CBD should not be rhetorically treated as an intoxicating controlled drug.
CBD as a possible precursor	CBD can be converted under deliberate chemical conditions, but the public record does not show frequent, material diversion of lawful CBD channels into illicit manufacture.	Convertibility alone is not enough for blanket precursor control.

Issue	What the evidence supports	Policy implication
HHC and intoxicating products	HHC is now internationally controlled as an end-product, and most EU Member States have moved to control it directly; expert regulators (UK ACMD) targeted the psychoactive semi-synthetics without controlling CBD.	The dangerous product can be controlled directly; restricting CBD does not address the core risk.
CBD as medicine	Purified CBD is authorised in the EU as Epidyolex for specific seizure disorders, with liver-risk management and monitoring; a BMJ umbrella review graded the seizure-reduction evidence as GRADE “high”.	Recognised medical use strengthens the case for category-specific, proportionate rules.
Safety and quality	CBD is not harmless: liver-enzyme elevations, drug interactions, a hazard-based reproductive-toxicity classification under review, mislabelling and contamination are real concerns.	These support testing, labelling, dose limits, hazard labelling and surveillance — not covert precursor prohibition.
Patient interests and EU law	Restrictions affecting patient access should be transparent, participatory, evidence-based and proportionate.	A measure affecting lawful CBD access should be justified by published evidence and a patient-impact assessment.

1. Regulatory baseline: CBD is not the same question as THC

CBD is found in cannabis and hemp and can also be produced synthetically. Pure CBD is non-intoxicating and is not internationally scheduled as a narcotic or psychotropic substance. That does not mean every product containing CBD is automatically lawful, safe or properly marketed. It means the policy question must be framed correctly.

A precursor restriction is a different legal tool from medicine regulation, food safety, cosmetics safety, vaping regulation or narcotic scheduling. It is designed to act against actual diversion into illicit manufacture. Where the practical effect would be to remove lawful CBD products from the market, the measure must also satisfy EU free-movement and proportionality standards, as the CJEU confirmed in Kanavape (C-663/18, 19 November 2020).

2. What the INCB notice does — and does not — prove

INCB PP Notice No. 1/2026 asks precursor focal points to increase vigilance, map supply chains, and report evidence of illicit manufacture, suspicious shipments, smuggling attempts or seizures involving CBD. It also reports that China voluntarily pre-notified large CBD export volumes through PEN Online Light (the INCB’s voluntary monitoring system for chemicals not controlled under the 1988 Convention).

That is not the same as proof of large-scale diversion from lawful CBD channels. The public record describes the evidence of CBD as the actual starting material for THC or semi-synthetic cannabinoids as “limited”. The Romanian HHC case is important precisely because it does not show diverted pharmaceutical or compliant consumer CBD as the feedstock: the actual starting material appeared to be industrial hemp / low-THC cannabis from which CBD was obtained on site. This suggests illicit operators source their own hemp feedstock — so a restriction on lawful consumer and pharmaceutical CBD would not stop production, but would strip patients of the tested, quality-controlled product they rely on.

The disciplined conclusion: vigilance is reasonable; a blanket or covert CBD precursor restriction is not justified without published evidence that lawful CBD channels are actually and materially being diverted.

3. Chemistry: convertibility is real, but it is not the same as market diversion

Context	What the evidence shows	What follows
Industrial synthesis	CBD can be converted into THC isomers or related cannabinoids under deliberate chemical conditions using reagents, solvents and purification.	This proves chemical possibility, not frequent illicit diversion from lawful CBD channels.
Human ingestion	Human pharmacokinetic evidence does not support the claim that oral CBD "turns into THC" in patients at clinically relevant levels.	Patient use should not be framed as self-intoxication or possession of a hidden THC source.
Vaping / heating	Some studies report conversion under specific laboratory conditions; realistic-device and matrix-specific findings are more conditional.	Regulate and test vape products specifically, instead of controlling CBD in all categories.
Analytical artefact	Certain analytical methods can create or exaggerate conversion / degradation signals inside instruments.	Policy decisions should rely on validated methods that distinguish real product content from artefact.

On human ingestion, the direct evidence is a 120-participant study in which oral CBD (300 mg) produced no Δ8- or Δ9-THC in blood and no intoxication, fed or fasted (Crippa et al. 2020). A later pharmacokinetic systematic review and meta-regression maps CBD's metabolism and is consistent with the same practical conclusion (Moazen-Zadeh et al. 2024): chemical convertibility under deliberate laboratory conditions is not the same as in-vivo conversion or real-world market diversion. On vaping and heating, realistic-device studies — including extreme power settings that degraded the hardware — found no relevant THC formation (Hindelang et al. 2022; Robertson et al. 2024), and vaping pure-CBD e-liquid produced no detectable THC in human blood (Kintz 2020); a single 2025 study formed THC isomers only in a non-standard cartridge-oil matrix (Kim et al. 2025), so the disciplined claim is "not reproduced under realistic consumer conditions", never "cannot occur". This brief deliberately does not reproduce reagents, catalysts or yields for the industrial conversion: convertibility is conceded, and the synthetic detail is irrelevant to the proportionality question and inappropriate for a public document.

4. Restricting CBD is not the way to address HHC or synthetic cannabinoids

The risk from intoxicating synthetic and semi-synthetic cannabinoids is real. Many grey-market products sold as "collector's items" expose users, including young people, to poorly characterised and sometimes potent substances. The question is whether restricting lawful CBD is the right tool. The evidence points the other way.

First, many of the most dangerous products are not made from CBD at all. The "Spice" family — fully synthetic cannabinoid receptor agonists (SCRAs) — are not derived from CBD; UN and UK expert assessments describe them as structurally distinct compounds synthesised from other, commonly available precursor chemicals. The UK ACMD states the chemistry plainly: "Cannabinoids with different side-chain lengths cannot be formed from CBD. They are instead synthesised from commonly available" and inexpensive precursors. Restricting CBD would not remove these products from the market.

Second, even where CBD is a relevant input, restricting lawful CBD does not stop the production chain. The one documented European case — the Romanian "Dream Factory" — obtained its CBD on site from industrial hemp, not from diverted pharmaceutical or compliant consumer supply. Illicit operators can source low-THC hemp or alternative inputs at will, switching when one route is closed; a restriction on lawful, tested CBD would displace the feedstock rather than remove the demand, while stripping patients of the quality-controlled product they rely on.

Third, the one intoxicant genuinely linked to CBD is already controlled. HHC was placed under international control as a psychotropic substance — Schedule II of the 1971 Convention, with the CND decision in force from 6 December 2025. The EU Drugs Agency has tracked the rapid spread of semi-synthetic cannabinoids across Europe — reporting dozens of such compounds and HHC detections in most reporting countries — and the great majority of EU Member States have already moved to control HHC directly. That is control of the dangerous end-product, under a different treaty and legal test from precursor control of CBD.

Regulators already draw this line. The UK ACMD examined semi-synthetic cannabinoids related to THC and CBD in 2025, recognised that CBD can be a starting point for some semi-synthetic products, and recommended controlling the psychoactive products — including the more potent long-chain variants — while expressly **not** recommending control of CBD itself; the UK Government accepted that direction. The proportionate model is to act against intoxicating end-

products, unlawful synthesis, misleading retail and youth access — while leaving lawful, tested CBD available to the patients who rely on it.

5. CBD is a recognised medicine, but every CBD product is not a medicine

Purified plant-derived CBD is the active ingredient in Epidyolex, an EU-authorised medicine for seizures associated with Lennox–Gastaut syndrome, Dravet syndrome and tuberous sclerosis complex; a BMJ umbrella review of meta-analyses rated the evidence for CBD's seizure-reduction effect as GRADE "high" (Solmi et al. 2023). EMA recognises important risks, including liver-related risks, and manages them through restrictions and regular monitoring — category-specific regulation in action.

This does not make every consumer CBD product a medicine, and it does not mean patient concerns disappear if one authorised medicine remains available. An important point of scale: prescribed Epidyolex is given at roughly 10–25 mg/kg/day (about 700–1,750 mg/day for a 70 kg adult), whereas most people using consumer CBD take on the order of 25–100 mg/day — ten to fifty times less (Boehnke et al. 2022). Policy and risk assessment built on the pharmaceutical dose do not automatically transfer to consumer products at these much lower doses. The categories should be kept distinct: medicines, novel foods / supplements, cosmetics, vaping products, herbal products, medical cannabis and illicit intoxicating cannabinoids.

6. Safety: the honest position is pro-regulation

The coalition does not claim CBD is harmless. Known and plausible risks include dose-dependent, reversible liver-enzyme elevations (a 2025 randomised trial found elevations in 8 of 151 adults at 5 mg/kg/day, versus none on placebo; Florian et al. 2025; a pooled analysis found no such cases below about 300 mg/day, far above typical consumer use; Lo et al. 2023), drug interactions, uncertainty around long-term food use, accidental child ingestion, mislabelling and contamination. Adverse effects in controlled trials are generally mild and dose-dependent (Chesney et al. 2020), CBD shows no meaningful abuse potential even at very high single doses (Schoedel et al. 2018), and in adults over 50 — the population most affected here — CBD-alone effects have been found essentially placebo-like (Velayudhan et al. 2021).

We also state the most recent adverse regulatory development plainly. On a February 2025 proposal from France's ANSES, the European Chemicals Agency's Risk Assessment Committee adopted an opinion in March 2026 (its RAC-77 plenary; press release ECHA/NR/26/15) recommending that CBD receive a harmonised classification as a presumed reproductive toxicant (CLP category Repr. 1B; H360FD, H362). It is important to be precise about what this is and is not. It is a **hazard** classification drawn largely from high-dose animal studies, not a finding of harm at the levels consumers actually encounter; it is **not yet in force** — the European Commission has still to decide whether to adopt it (legal deadline around August 2026), and any resulting restriction would not take effect before 2027; and it is **contested**, with industry seeking the lower Category 2. We do not minimise it. But note where it lives and how it is already being handled: a CLP reproductive-toxicant classification operates through chemical-hazard labelling and the EU Cosmetics Regulation — not through drug-control law — and on the parallel risk-based question the Commission's own Scientific Committee on Consumer Safety found CBD safe for use in cosmetics at concentrations up to 0.19% (SCCS/1685/25, 2026). The newest safety signal is therefore being assessed and managed by the correct, category-specific instruments. That is exactly the point: every genuine concern about CBD has a proportionate home in medicines, food, cosmetics or chemical-hazard law — none of which is precursor control.

On dose, precision matters. EFSA's 2026 update set a provisional safe intake for CBD as a novel food of 0.0275 mg/kg body weight per day — roughly 2 mg/day for a 70 kg adult — in a specific high-purity (≥98%) food-supplement context, with important exclusions (it does not extend to people under 25, pregnant or lactating women, or those on medication) and acknowledged data gaps. That is not a market authorisation, and it is strikingly conservative. A separate peer-reviewed safety assessment (Henderson et al. 2023, industry-commissioned and disclosed) proposed a potential acceptable daily intake of 0.43 mg/kg bw/day — about 30 mg/day for a 70 kg adult — with recommended supplement upper intake limits of 70 mg/day for healthy adults generally (a figure itself derived from the animal reproductive endpoints now before ECHA), rising to 100–160 mg/day for adults who are not trying to conceive, pregnant or lactating. Consumers themselves report doses in the tens of milligrams, for example a median near 67 mg/day among people using CBD for fibromyalgia (Boehnke et al. 2022). Those figures differ, but every one of them points to product-specific safety rules, not precursor prohibition. A measure built on the dosing and risk profile of a high-dose prescription medicine, or on the most conservative provisional food figure, would not be proportionate to a consumer product taken in tens of milligrams.

The FDA reached a similar regulatory logic in 2023: existing food and supplement frameworks were not adequate for CBD, and a new pathway should include safeguards such as clear labels, contaminant controls, CBD content limits and measures to reduce accidental child ingestion. These are real issues — and every one of them supports dose limits, warnings, contraindications, batch testing, adverse-event monitoring, age restrictions where relevant, hazard labelling where a classification is finalised, and medical supervision for authorised medicines. None of them, without diversion evidence, supports treating lawful CBD as a drug precursor.

7. Product quality: evidence for standards, not prohibition

Independent testing of commercially available CBD products has repeatedly found label and contamination problems. A 2024 analysis of 202 US products found that about three-quarters deviated from labelled CBD potency by at least 10%, with heavy metals (44 products), residual solvents (181) and pesticides (30) detected (Gidal et al. 2024); an earlier JAMA analysis found that roughly seven in ten online CBD extracts were over- or under-labelled (Bonn-Miller et al. 2017); and European-market analysis reports comparable labelling discrepancies (Melchert et al. 2024).

The deeper point for a precursor proposal is the gap between regulated and illicit supply. In a Health Canada comparison of 50 licensed and 50 illicit cannabis samples, 94% of illicit samples carried pesticide residues (averaging 3.4 compounds each, across 24 different active ingredients) against trace detections in only two licensed samples; mycotoxins were absent from licensed products but present in 12% of illicit ones; and microbial limits were breached far more often on the illicit side (Fiering et al. 2026), consistent with earlier multi-residue work showing roughly nine in ten illicit samples contaminated versus about one in twenty regulated (Gagnon et al. 2023). Because such data depend on market and sampling context, they should not be over-generalised to every EU product. But the policy lesson is clear: consumers and patients need enforceable standards — validated cannabinoid analysis, contaminant limits, batch testing and traceability, accurate labels and market surveillance — not an unregulated market. Removing tested CBD does not remove demand; it shifts patients toward exactly the unregulated, worse-contaminated supply the data describe.

8. Real-world evidence and patient impact

Real-world evidence is not a substitute for high-quality randomised controlled trials. It is, however, a legitimate part of modern evidence assessment — recognised by the FDA in product-lifecycle decisions and by the EMA in its reflection paper on real-world data and real-world evidence — especially for safety signals, tolerability, adherence, quality of life and the experience of older, comorbid or medically complex patients often excluded from trials (Schlag, Nutt et al. 2022). We also note the documented phenomenon of “reverse spin bias”, in which some systematic reviews understate genuine benefit even where their own data show a statistically significant effect (O’Leary et al. 2026).

The immediate policy question is not whether CBD is proven for every claimed use. It is whether government should restrict access before publishing evidence that such restriction is necessary, proportionate and targeted to a demonstrated diversion risk. Any proposed restriction should include a patient-impact assessment and formal consultation with patient organisations.

9. Legal and patient-interest standard: evidence, necessity, proportionality

The campaign does not assert a free-standing legal right to any product. It argues that a proposed administrative restriction of CBD may affect established rights and interests — patient autonomy, dignity, access to appropriate care, transparent decision-making and non-discrimination, reflected in instruments such as the right to health (ICESCR Art. 12) and the Oviedo Convention — and therefore must be transparent, participatory and proportionate.

In Kanavape, the CJEU held that a Member State may not prohibit CBD lawfully produced in another Member State unless the measure is appropriate, necessary, and does not go beyond what is required for public-health protection; the risk “cannot be based on purely hypothetical considerations” and must be sufficiently established. The CBD in that case was produced in the Czech Republic, making the precedent directly relevant. France’s Conseil d’État applied the same logic, annulling a general ban on CBD flowers and leaves as disproportionate (2022), noting CBD does not alter consciousness or cause dependence. The European Commission has also issued a detailed opinion on Czech psychomodulatory-substance measures under TRIS Notification 2025/0093/CZ (the detailed opinion is dated 12 May 2025); under Directive 2015/1535/EU, a Member State that proceeds after such a detailed opinion bears the burden of showing the measure is consistent with EU law. A further case on national CBD restrictions, C-495/25 (Syndicat professionnel du chanvre), is pending before the CJEU and will refine the Kanavape principle.

The proportionate model already exists in Czech law. When the Czech Republic faced a genuinely intoxicating cannabinoid — HHC, including cases of children harmed by HHC sweets — it did not reach for prohibition; it enacted the Psychomodulatory Substances Act (No. 85/2024 Coll., in force 1 July 2025): licensing, an 18+ age limit, packaging and labelling rules, content limits and a time-limited review for emerging substances. The same country whose lawfully produced CBD anchored Kanavape met a real intoxicant with proportion. To place a non-intoxicating molecule under a heavier, narcotics-precursor regime than the one applied to an actual intoxicant would be a regulatory contradiction.

These standards do not forbid CBD regulation; they require evidence-based, proportionate regulation. A covert precursor restriction based on limited evidence would be difficult to reconcile with them.

10. A proportionate alternative

- Publish the evidence relied upon for any proposed CBD restriction, including diversion, seizure and clandestine-laboratory data.
- Use precursor tools against suspicious shipments, actual diversion and documented illicit manufacture — not against lawful CBD by default.
- Control HHC and other intoxicating synthetic / semi-synthetic cannabinoids directly, including unlawful manufacture and misleading retail.
- Require validated cannabinoid analysis, contaminant testing, batch traceability and accurate labelling for lawful CBD products.
- Keep medicines, foods / supplements, cosmetics, vaping products and medical cannabis under their correct legal regimes, including chemical-hazard labelling where a classification is finalised.
- Set dose limits, warnings, contraindications, child-protection rules and age restrictions where the evidence supports them.
- Consult patient organisations and publish a patient-impact assessment before any measure affecting treatment access or lawful supply.

What would change our position? We would support a proportionate precursor measure on a published record showing: documented diversion of lawful CBD channels into clandestine manufacture at material scale; evidence that narrower, category-specific controls cannot manage the risk; and a published patient-impact assessment. The INCB notice itself calls the present evidence "limited" and asks focal points to gather it. We ask government to publish it.

What we do not claim

- We do not claim every CBD product is safe.
- We do not claim CBD treats every condition.
- We do not claim CBD cannot be chemically converted into THC or related cannabinoids under deliberate conditions.
- We do not deny that intoxicating synthetic and semi-synthetic cannabinoids require control.
- We do not minimise the reproductive-toxicity classification under review; we say it belongs to chemical-hazard and cosmetics law, not drug-control law.
- We do not oppose proportionate rules on testing, labelling, dose, age limits, medicines oversight, food safety, hazard labelling or enforcement against illicit synthesis.
- We oppose a blanket or covert precursor-based restriction unless government publishes evidence sufficient to show it is necessary and proportionate.

Decision requested

- Do not classify or restrict pure CBD as a drug precursor unless government can publish evidence that CBD in lawful channels is actually and materially being diverted or used for illicit manufacture.
- Maintain patient access while using targeted controls against intoxicating semi-synthetic cannabinoids, unlawful synthesis, misleading retail, youth access, mislabelling and contamination.
- Publish the evidence, consult affected patients and experts, and apply proportionate regulation rather than covert or blanket restriction.

Take action — sign the petition

Read and sign the official petition, *"Care Before Discrimination — Patients' Rights and the Proposed Restriction of CBD,"* in your language:

- **English** — https://www.openpetition.eu/petition/online/care-before-discrimination-is-a-human-right
- **Čeština / Czech** — https://www.openpetition.eu/petition/online/pece-pred-diskriminaci-prava-pacientu-a-navrhovane-omezeni-cbd
- **Deutsch / German** — https://www.openpetition.eu/petition/online/fuersorge-vor-diskriminierung-ist-ein-menschenrecht
- **Español / Spanish** — https://www.openpetition.eu/petition/online/el-cuidado-antes-que-la-discriminacion-es-un-derecho-humano
- **Français / French** — https://www.openpetition.eu/petition/online/le-soin-avant-la-discrimination-est-un-droit-humain
- **Italiano / Italian** — https://www.openpetition.eu/petition/online/la-cura-prima-della-discriminazione-e-un-diritto-umano

Read the full Official Appeal (PDF, available in EN · CZ · ES · FR · DE · IT) and the evidence dossier at **https://cbdhumanright.org**.

References and source notes

Grouped by class. Identifiers are given so load-bearing claims can be checked. The INCB PP Notice No. 1/2026 is headed "For Official Use Only"; for the public record this brief relies on the INCB public Precursors Report for 2025 (E/INCB/2025/4).

Law, treaty and regulatory determinations.

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2. International Narcotics Control Board. *Precursors Report for 2025*, E/INCB/2025/4; and *PP Notice No. 1/2026 — Observations concerning cannabidiol (CBD)*, 24 Feb 2026. Public point used here: vigilance requested; evidence of actual precursor use described as limited.
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4. UK Advisory Council on the Misuse of Drugs. *"Semi-synthetic" cannabinoids: cannabinoids related to tetrahydrocannabinol and cannabidiol*, May 2025, with UK Government responses (Aug 2025; 11 May 2026). Targeted the psychoactive semi-synthetics, not CBD; states that cannabinoids of other side-chain lengths cannot be formed from CBD, and distinguishes the fully-synthetic SCRAs from CBD-related semi-synthetics.
5. Court of Justice of the EU. Case C-663/18, *"Kanavape"*, Judgment 19 Nov 2020, ECLI:EU:C:2020:938. CBD lawfully produced in another Member State may not be prohibited unless the risk is sufficiently established and the measure necessary and proportionate; the CBD was produced in the Czech Republic.
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Conversion chemistry (CBD → THC, vaping, analytical artefact).

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This brief advocates on a question of health policy. It does not promote, sell or link to any CBD product. Where evidence is contested or developing, the uncertainty is stated. It accompanies the Official Appeal, "Care Before Discrimination — Patients' Rights and the Proposed Restriction of CBD." · cbdhumanright.org · v4.1 · 17 June 2026.