

1 **Doctor or drug dealer? International legal provisions for**  
2 **the legitimate handling of drugs of abuse**

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# 1 **Doctor or drug dealer? International legal provisions for** 2 **the legitimate handling of drugs of abuse**

## 3 **Abstract**

4 In this paper, we compare how five jurisdictions (the USA; UK; Canada; New  
5 Zealand; and Australia) balance the disparate objectives of preventing the misuse of  
6 drugs and allowing their legal use for medical purposes. The statutory law  
7 underpinning each country's method of categorising drugs depict distinctive outlooks  
8 from the different jurisdictions, as each works towards these same goals. In  
9 examining how each country's legislation deals with controlled substances, initial  
10 consideration will be given to whether drugs are categorised once only, or twice:  
11 once for dealing with their criminal misuse; and again for ensuring their safe  
12 medicinal use.

13 In effectively dealing with criminal activities associated with drugs of abuse,  
14 Australia's system of imposing penalties based on the quantity of a drug possessed,  
15 rather than on its grouping with other drugs of a broadly similar type offers the most  
16 flexibility. In terms of managing the legitimate use of such drugs, however, it is  
17 perhaps the least flexible of the four jurisdictions operating parallel systems of  
18 categorisation. The greatest level of flexibility is offered by Canada and the UK,  
19 which have functionally very similar protocols in this respect.

## 20 **Keywords**

21 Comparative law; categorisation of drugs; international drug statutes

22

# 1 Introduction

2 National drug-control legislation has a two-fold remit, namely: to carry out provisions  
3 of international drug control treaties; and to allow legal use of drugs for useful  
4 (usually medical) purposes.

5 Such legislation represents action in line with treaty commitments under the three  
6 major drug control treaties currently in force, namely: the Single Convention on  
7 Narcotic Drugs (**Single Convention, 1961**), the Convention on Psychotropic  
8 Substances (**Psychotropic Convention, 1971**), and the Convention against Illicit  
9 Traffic in Narcotic Drugs and Psychotropic Substances (**Traffic Convention, 1988**).

10 The Single Convention on Narcotic Drugs of 1961 is an international treaty to prohibit  
11 production and supply of named narcotic drugs except under licence for specific  
12 purposes, such as research and medical treatment. As its scope was limited to drugs  
13 with opium-like effects, coca and cannabis, the Single Convention did not ban the  
14 many newly-discovered psychoactive drugs, such as amphetamines, barbiturates,  
15 benzodiazepines, and psychedelics, and these were subsequently dealt with under  
16 the Psychotropic Convention. The Traffic Convention provides additional legal  
17 mechanisms for enforcing the Single Convention and the Psychotropic Convention.

18 Since the Single Convention is not self-executing, signatories must pass laws to  
19 carry out its provisions, and the United Nations Office on Drugs and Crime (UNODC)  
20 works with countries' legislatures to ensure timely implementation. As a result, most  
21 of the national drug statutes in the UNODC's legal library share a high degree of  
22 conformity with the Single Convention and its supplementary treaties. The Single  
23 Convention has been used as the basis for the standardisation of national drug-  
24 control laws.

25 Parallel to meeting international treaty obligations, national laws must make  
26 provision for the safe and secure use of drugs for the benefit of society. This is  
27 generally achieved by the implementation of so-called *regimes of control*, which may  
28 include provisions for safe custody, record-keeping, sale, supply, administration, and  
29 destruction.

30 Here, we compare how five jurisdictions with roots in English common law – namely:  
31 the USA; UK; Canada; New Zealand; and Australia – balance these opposing

1 objectives. The legal provisions underpinning each jurisdiction's method of  
2 categorising drugs depict distinctive outlooks from the different authorities, as each  
3 works towards these same goals. In examining how each country's legislation deals  
4 with controlled substances, initial consideration will be given to whether drugs are  
5 categorised once only, or twice: once for dealing with their criminal misuse; and  
6 again for ensuring their safe medicinal use, as outlined in **Figure 1**. Where dual  
7 categorisation is applied, a comparison of the subtly different systems and how their  
8 two categories interplay will be made. We will discuss the relative merits of each of  
9 the constituent legislative provisions from all five jurisdictions with a view to  
10 assessing their relative strengths and weaknesses, and to assessing whether the  
11 strongest and most flexible examples from each category could be combined for the  
12 purpose of maximising medical benefit while minimising misuse.

	<b>Criminal</b>	<b>Medical</b>
(a)	<b>United States</b>	
	<b>Controlled Substance Act 1970</b>	
	Schedule I Schedule II Schedule III Schedule IV Schedule V	
(b)	<b>United Kingdom</b>	
	<b>Misuse of Drugs Act 1971</b>	<b>Misuse of Drugs Regulations 2001</b>
	Class A Class B Class C	Schedule 1 Schedule 2 Schedule 3 Schedule 4 Schedule 5
(c)	<b>Canada</b>	
	<b>Controlled Drugs and Substances Act 1996</b>	<b>NCRs</b> Narcotics
	Schedule I Schedule II Schedule III Schedule IV Schedule V	<b>FDRs</b> Controlled drugs
		<b>BOTSRs</b> Targeted substances
(d)	<b>New Zealand</b>	
	<b>Misuse of Drugs Act 1975</b>	<b>Misuse of Drugs Regulations 1977</b>
	Class A → [1 part]	[Part 1] Part 2 Part 3 Part 4 Part 5 Part 6 Part 7]
	Class B → [Part 1]	
	Class C → [Part 2]	
(e)	<b>Australia</b>	
	<b>Drug Misuse and Trafficking Act 1985</b>	<b>Poisons Standard</b>
	Schedule I (penalty imposed depends on quantity)	Schedule 8

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2 **Figure 1: Overview of the legal classification of drugs of misuse in (a) the United**  
 3 **States, (b) the United Kingdom, (c) Canada, (d) New Zealand, and (e) Australia.**

4 **Legislation prohibiting the possession, etc. of such drugs are listed in the left column**  
 5 **("Criminal"), and regulations enabling their legitimate use in the right column**  
 6 **("Medical").**

# 1 USA

## 2 ***Controlled substances***

3 The Controlled Substance Act 1970 is the federal legislation controlling manufacture,  
4 importation, possession, use, and distribution of controlled substances, including  
5 hallucinogens, narcotics, depressants, and stimulants (**Controlled Substances Act**  
6 **1970; s. 801**). The Act categorises drugs into five schedules based on their potential  
7 for abuse, any medical benefits they may provide, and their risk to health (**Controlled**  
8 **Substances Act 1970; s. 812**). Schedule I substances, for example, have a high  
9 potential for abuse, have no currently accepted medical use in treatment in the US,  
10 and are considered unsafe for use, even under medical supervision (**Controlled**  
11 **Substances Act 1970; s. 812(b)(1)**). This schedule includes diamorphine, LSD,  
12 mescaline and peyote. To be valid, a controlled substance prescription must be  
13 issued for a legitimate medical purpose by an individual practitioner acting in the  
14 usual course of his professional practice (**21 CFR; s. 1306.04(a), 2001**). As such,  
15 healthcare practitioners may not legitimately hold stocks of Schedule I drugs. At the  
16 bottom end of the scale, Schedule V drugs, such as pregabalin, have a low potential  
17 for abuse, a currently accepted medical use, but may lead to limited physical or  
18 psychological dependence. Substances in Schedules II-IV contain drugs with  
19 increasing medical benefits and reducing abuse potential between these two  
20 extremes (**Table 1**).

21 The Controlled Substance Act was drafted to achieve uniformity between State laws  
22 and those of the Federal government. It is a uniform Act sponsored by the Uniform  
23 Law Commission (ULC) and intended to be enacted by each individual state with or  
24 without changes (**Guide to Uniform and Model Acts, 2018**). It provides an interlocking  
25 trellis of Federal and State law to enable government at all levels to control more  
26 effectively the drug abuse problem, and has been adopted by 44 States, including  
27 California, which we will use as an exemplar in this discussion (**Uniform Controlled**  
28 **Substances Act 1973**).

29 In California's Uniform Controlled Substances Act 1973, controlled substances are  
30 those listed in s.11054-11058 (**Uniform Controlled Substances Act 1973; s.11053**).

31

1 **Table 1: Descriptors for abuse potential and medical benefit for controlled**  
 2 **substances as outlined in The Controlled Substances Act 1970, together with**  
 3 **examples from California's Uniform Controlled Substances Act 1973.**

Schedule	Abuse potential	Medical use	(Addiction potential)	Examples
1	High	None	Unsafe, even under medical supervision	Diamorphine; dipipanone
2	High	Accepted (potentially with severe restrictions)	Severe psychological or physical dependence	Oxycodone; morphine; codeine
3	Less than Schedules 1 or 2	Accepted	Low or moderate physical dependence or severe psychological dependence	Ketamine; secobarbital
4	Less than Schedule 3	Accepted	None	Diazepam; modafinil
5	Less than Schedule 4	Accepted	Preparations containing limited quantities of certain narcotics	Not more than 200 milligrams of codeine per per 100 grams

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# 1 UK

## 2 ***Controlled drugs***

### 3 *Classes*

4 The Misuse of Drugs Act 1971 controls the export, import, production, supply and  
5 possession of dangerous or otherwise harmful drugs (**Misuse of Drugs Act 1971; ss.**  
6 **3-7A**). These substances are listed in Schedule 2 to the Act, and the term “controlled  
7 drug” means any substance or product so listed. The Schedule is divided into three  
8 parts or classes largely on the basis of decreasing order of harmfulness: Part I  
9 (Class A); Part II (Class B); and Part III (Class C). This division into three classes is  
10 solely and specifically for the purpose of determining penalties for offences under the  
11 Act (**Misuse of Drugs Act 1971; s. 25**).

12 Although the Act functions primarily to prohibit any of the activities listed above, it is  
13 recognised that many controlled drugs have useful – often medical – functions, and  
14 allowance is made in s. 10 of the Act for regulations to be made preventing the  
15 misuse of controlled drugs in such circumstances.

### 16 *Schedules*

17 The Misuse of Drugs Regulations 2001 arrange controlled drugs into five schedules  
18 defined by the regimes of control which must be applied to these drugs when used  
19 for lawful purposes (**Misuse of Drugs Regulations 2001**).<sup>1</sup> The five schedules are  
20 numbered in descending order of control, with the most stringent controls applying to  
21 drugs in Schedule 1.

22 Schedule 1 controlled drugs have no recognised medical use, and their production  
23 and possession is limited to purposes of research or other special purposes. Very  
24 few classes of person (e.g. police constables) have a general authority to possess  
25 these drugs in the course of their work, but others may only produce, supply or  
26 possess the drugs within the authority of a licence issued by the Secretary of State  
27 for the Home Department. (**Misuse of Drugs Regulations 2001; reg. 7**)

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<sup>1</sup> In England, Scotland and Wales, controlled drugs are scheduled under the Misuse of Drugs Regulations 2001. In Northern Ireland, the same outcome is achieved under the Misuse of Drugs Regulations (Northern Ireland) 2002.

1 Schedule 2 includes opiates, amphetamines, and other drugs with a high potential  
2 for misuse. A licence is needed to import or export drugs in this schedule, but they  
3 may be manufactured or compounded by a practitioner, or a pharmacist when acting  
4 in their capacity as such, or a person holding an appropriate licence. A pharmacist  
5 may supply a Schedule 2 controlled drug to a patient only on the authority of a  
6 prescription in the required form issued by an appropriate practitioner. (Misuse of  
7 Drugs Regulations 2001; regs. 15 and 16) Special requirements as to custody and  
8 destruction apply to these drugs, and the provisions relating to labelling of containers  
9 and the keeping of records must also be observed (Misuse of Drugs Regulations  
10 2001; regs. 18 and 19).

11 Most barbiturates and a number of minor stimulants are listed in Schedule 3, which  
12 are not thought likely to be so harmful when misused as the drugs in Schedule 2.  
13 The number of regulations that apply to each schedule are reduced as the schedule  
14 number increases, as outlined in Table 2. For example, Schedule 2 drugs are  
15 subject to record-keeping obligations under reg.19 of the regulations, which do not  
16 apply to other Schedules; and drugs in Schedules 2 and 3 have specific  
17 requirements as to the form of prescriptions (reg. 15), which are not applicable to  
18 Schedule 4 or 5 drugs.

19 Schedule 4 is split into two parts: Part I contains the benzodiazepines, save a few  
20 such as flunitrazepam and temazepam, which are in lower schedules for safety  
21 reasons; Part II contains the anabolic and androgenic steroids. The major difference  
22 between the two classes is that there is no restriction on the importation of Part II  
23 drugs for self-administration (Misuse of Drugs Regulations 2001; reg. 4(2)).

24 Schedule 5 specifies those preparations of certain Controlled Drugs for which there  
25 is only negligible risk of abuse, such as compound analgesics and opiate-based  
26 antitussives.

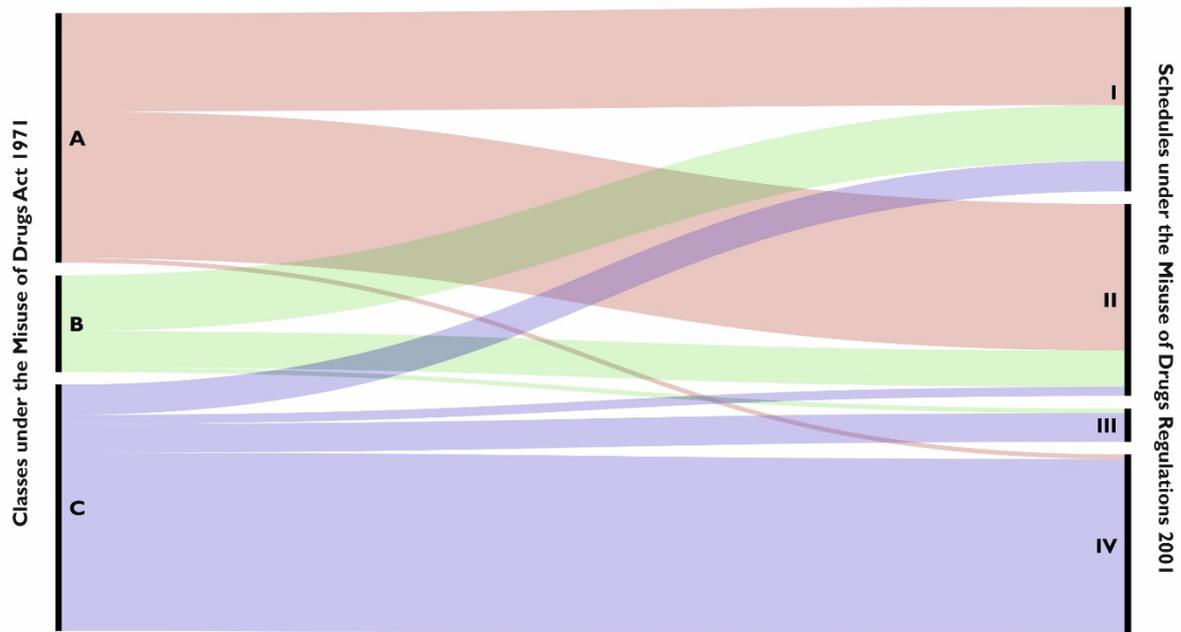
27 **Table 2: UK Misuse of Drugs Regulations 2001 and the schedules of controlled**  
28 **drugs to which they apply. Note that for Schedules 2 to 5, as the schedule increases,**  
29 **the number of regulations applied to the drugs within it decrease.**

<b>Schedule</b>	<b>Regulations that apply</b>
Schedule 1	14, 15, 16, 18, 19, 20, 23, 26, 27

Schedule 2	14, 15, 16, 18, 19, 20, 21, 23, 26, 27
Schedule 3	14, 15*, 16, 18, 22, 23, 24, 26, 27
Schedule 4, Part I	22, 23, 26, 27
Schedule 5	24, 26
*except temazepam	

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2 The UK effectively maintains two separate lists of the same controlled drugs: one for  
3 the purpose of preventing crime; and another for ensuring the safe and secure use of  
4 such drugs for legitimate reasons, such as the treatment of injury (**Figure 2**). These  
5 two lists are largely independent of one another: to move a drug from one class to  
6 another, for example, requires the amendment of the 1971 Act, while changing its  
7 schedule involves amending the 2001 Regulations. This level of independence  
8 allows a drug's potential for abuse to be considered separately to its accepted  
9 medical use when determining how it should be categorised. For example,  
10 ethylphenidate, a stimulant with only moderate potential for misuse, but with no  
11 recognised therapeutic use, is classified as Class B and Schedule 1, while  
12 diamorphine, which has a significant history of abuse and an established medical  
13 function can be categorised as Class A and Schedule 2. In contrast, diamorphine is  
14 not a licensed medicine in the US, as its potential for abuse is deemed to far  
15 outweigh its benefits through legitimate use, when both are considered together.



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2 **Figure 2:** Alluvial diagram showing how the same 393 controlled drugs (or families  
 3 of structurally-related drugs) are categorised into three classes for the purpose of  
 4 fixing penalties, and five schedules for the purpose of maintaining regimes of control,  
 5 in the United Kingdom.

6 **Canada**

7 **Controlled substances**

8 The Controlled Drugs and Substances Act 1996 (CDSA) categorises all synthetic  
 9 and natural forms of controlled substances in terms of offenses and penalties  
 10 associated with their misuse. Controlled substances are defined as those named in  
 11 Schedules I-V of the Act (**Controlled Drugs and Substances Act 1996; s.2.2**) with  
 12 Schedule I substances attracting the most severe penalties, and Schedule V the  
 13 least severe. Substances are placed in their respective schedules based on whether  
 14 they have a currently accepted medical use in treatment in Canada, their relative  
 15 abuse potential, and their likelihood of causing dependence when abused.

16 The Governor-in-Council may define new regulations, to enforce the requirements of  
 17 the Act. This includes, but is not limited to, regulations regarding medical application  
 18 and distribution of controlled drugs (**Controlled Drugs and Substances Act 1996; s.**  
 19 **55(1)**). The Governor-in-Council may specify regulations affecting, for example, the  
 20 importation and exportation of controlled substances, their administration,

1 production, and packaging (**Controlled Drugs and Substances Act 1996; s. 55(1)(a)**).  
2 Qualifications required by an individual performing certain activities with regard to  
3 controlled substances may be specified by such regulations (**Controlled Drugs and**  
4 **Substances Act 1996; s. 55(1)(h)**).

## 5 ***Narcotics and controlled drugs***

6 Medicines containing controlled substances are scheduled according to the  
7 regulatory framework within the CDSA. They are further categorised in terms of  
8 regimes of control in accordance with several sets of regulations, namely: the  
9 Narcotic Control Regulations (NCRs); the Food and Drug Regulations (FDRs); and  
10 the Benzodiazepines and Other Targeted Substances Regulations (BOTSRs).

### 11 *Narcotics*

12 Narcotics are defined as those substances listed in the schedule to the NCRs, and  
13 include: opiates; coca alkaloids; phenylpiperidines; moramides; morphinans; and  
14 fentanyl. Any preparation intended for parenteral use; or containing only narcotic  
15 substances (excluding excipients), or fewer than two non-narcotic medicinal  
16 substances; or containing diamorphine, hydrocodone, methadone, oxycodone, or  
17 pentazocine is defined as a narcotic drug. Narcotic preparations, also referred to as  
18 verbal prescription narcotics, are those containing only one narcotic substance  
19 together with two or more other medicinal ingredients at a recognised therapeutic  
20 dose (**Narcotic Control Regulations; reg. 2**).

### 21 *Controlled drugs*

22 Controlled drugs are categorised in three parts, listed in the schedule to Part G of the  
23 FDRs. The schedule is further subdivided into three parts. Part 1 includes  
24 amphetamines; Part 2 lists barbiturates; and Part 3 contains the anabolic steroids.

### 25 *Benzodiazepines and other targeted substances*

26 Targeted substances are those listed in Schedule 1 of the BOTSRs. They are sub-  
27 sorted in two classes. Class 1 Targeted Substances include most benzodiazepines,  
28 meprobamate, zolpidem, and other depressants. There is currently only one Class 2  
29 substance: the benzodiazepine, flunitrazepam. Schedule 2 of the regulations lists the  
30 specified names (essentially, the international nonproprietary names) of the Targeted  
31 Substances listed in Schedule 1.

# 1 New Zealand

## 2 ***Controlled drugs***

3 A controlled drugs is any substance, preparation, mixture, or article specified or  
4 described in Schedule 1, Schedule 2, or Schedule 3 of the Misuse of Drugs Act 1975  
5 (**Misuse of Drugs Act 1975; s. 2**). Schedule 1 lists all Class A controlled drugs, Class  
6 B controlled drugs are listed in Schedule 2, and Schedule 3 catalogues all controlled  
7 drugs in Class C. Precursor substances are listed in Schedule 4. The classification of  
8 a drug under the Act is based on the risk of harm the drug poses to individuals, or to  
9 society, by its misuse (**Misuse of Drugs Act 1975; s. 3A**). Drugs that pose a very high  
10 risk of harm are classified as Class A drugs; drugs posing a high risk of harm are  
11 Class B; and those posing a moderate risk are in Class C.

12 Schedule 2 of the Act is further subcategorised into three parts; Schedule 3 is split  
13 into seven parts. The different regimes of control needed to allow controlled drugs to  
14 be put to their legitimate uses are contained in the Misuse of Drugs Regulations  
15 1977, which were drafted with specific reference to these parts under s. 37 of the  
16 Act. Schedule 1 and Part 1 of Schedule 2 are subject to regulations restricting import  
17 and export (**Misuse of Drugs Regulations 1977; reg. 7**), supply (**Misuse of Drugs  
18 Regulations 1977; reg. 22**), labelling (**Misuse of Drugs Regulations 1977; reg. 25**)  
19 and custody (**Misuse of Drugs Regulations 1977; reg. 28**), as well as those which  
20 apply to the much less-regulated Parts 6 and 7 of Schedule 3 (**Misuse of Drugs  
21 Regulations 1977; regs. 29, 31, 31A, and 35**) with other parts subject to various  
22 intermediate regimes (**Table 3**).

23 **Table 3: New Zealand Misuse of Drugs Regulations and the categories of controlled**  
24 **drugs, as described in the Misuse of Drugs Act 1975 to which they apply.**

<b>Class</b>	<b>Schedule</b>	<b>Regulations that apply</b>
Class A	Schedule 1	3, 7, 22, 25, 28, 29, 31, 31A, 33, 35
Class B	Schedule 2, Part 1	3, 7, 22, 25, 28, 29, 31, 31A, 33, 35
	Schedule 2, Part 2	22, 25, 28, 29, 31, 31A, 33, 35
	Schedule 2, Part 3	25, 28, 29, 31, 31A, 33, 35

Class C	Schedule 3, Part 1	3, 7, 22, 25, 28, 29, 31, 31A, 35
	Schedule 3, Part 2	25, 28, 29, 31, 31A, 35
	Schedule 3, Part 3	25, 28, 29, 31, 31A, 35
	Schedule 3, Part 4	25, 28, 29, 31, 31A, 35
	Schedule 3, Part 5	25, 29, 31, 31A, 35
	Schedule 3, Part 6	29, 31, 31A, 35
	Schedule 3, Part 7	29, 31, 31A, 35

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## 2 **Australia**

### 3 ***Prohibited drugs***

4 In Australia, laws concerning the possession, supply and manufacture of illicit drugs  
5 are largely the remit of States and Territories. As a consequence, illicit drugs are  
6 defined slightly differently in each jurisdiction: however, there are federal controls  
7 over imports and exports by virtue of international treaty obligations.

8 The Commonwealth *Narcotic Drugs Act (1967)* implements the Single Convention  
9 (1966), and defines prohibited drugs by reference to it. Each of Australia's six states  
10 and two mainland territories legislate separately to list the drugs and substances  
11 prohibited in each jurisdiction, though there is near uniformity in their respective lists.  
12 In New South Wales (NSW), Schedule 1 of the Drug Misuse and Trafficking Act  
13 1985 lists all prohibited drugs for the purpose of defining offences (**Drug Misuse and**  
14 **Trafficking Act 1985**). There is no explicit distinction between classes of drugs within  
15 the schedule as exists in the UK: rather, the seriousness of the penalty imposed  
16 depends on the weight or quantity of the drug seized, as set out in the schedule. For  
17 example, a person found with less than 3g of cocaine would most likely be charged  
18 with the summary offence of possession (**Drug Misuse and Trafficking Act 1985; s.**  
19 **10**); and a person in possession of between 3g and 5g would be required to prove on  
20 the balance of probabilities that he or she had the drug otherwise than for supply  
21 (**Drug Misuse and Trafficking Act 1985; ss. 30-31**); while someone possessing 5g or  
22 more would automatically face the indictable charge of supply (**Drug Misuse and**  
23 **Trafficking Act 1985; s. 25**). Unlike the other countries discussed here, which classify

1 drugs into three or five classes or schedules for the purpose of setting penalties,  
2 Australia has a single schedule, which provides cut-off amounts for each drug with  
3 regard to various offences, such as possession and trafficking (**Table 4**). It has, in  
4 effect, 368 drug classes: one for each of the substances listed in Schedule 1 of the  
5 Act.

## 6 **Medicines**

7 As with prohibited drugs, medicines are classified on a state-by-state basis against  
8 federally-agreed standards. The Advisory Committee on Medicines Scheduling  
9 (ACMS) established under paragraph 52B of the (Commonwealth) Therapeutic  
10 Goods Act (1989) makes decisions at a federal level on the Standard for Uniform  
11 Scheduling of Medicines and Poisons (SUSMP), or Poisons Standard (**Standard for**  
12 **Uniform Scheduling of Medicines and Poisons, 2019**). ACMS decisions on the  
13 SUSMP do not in themselves have the force of law: rather they are  
14 recommendations for incorporation into state and territory legislation. The Poisons  
15 Standard categorises all medicines and controlled drugs into ten schedules (**Table**  
16 **5**). Schedule 8 lists controlled drugs.

17

**Table 4:** Extract from Schedule 1 of the New South Wales Drug Misuse and Trafficking Act 1985 giving cut-off amounts of selected common prohibited drugs for the purpose of determining offences under Part 2 of the Act. For example, a person who has not less than the traffickable quantity is deemed to have the prohibited drug in his or her possession for the purpose of supply.

<b>Prohibited plant or drug</b>	<b>Small</b>	<b>Traffickable</b>	<b>Indictable</b>	<b>Commercial</b>	<b>Large commercial</b>
Cannabis resin	5.0g	30.0g	90.0g	2.5kg	10.0kg
Cocaine	1.0g	3.0g	5.0g	0.25kg	1.0kg
Flunitrazepam	0.2g	0.6g	1g	0.1kg	0.5kg
Heroin	1.0g	3.0g	5.0g	0.25kg	1.0kg
Hydrocodone	1.0g	3.0g	5.0g	0.5kg	2.0kg
Methylamphetamine	1.0g	3.0g	5.0g	0.25kg	0.5kg
Morphine	1.0g	3.0g	5.0g	0.25kg	1.0kg
Oxycodone	2.5g	7.5g	12.5g	1.25kg	5.0kg

1 **Table 5: Schedules in the Standard for Uniform Scheduling of Medicines and**  
 2 **Poisons (Australia).**

<b>Schedule 1</b>	Not currently in use
<b>Schedule 2</b>	Pharmacy Medicine
<b>Schedule 3</b>	Pharmacist Only Medicine
<b>Schedule 4</b>	Prescription Only Medicine
<b>Schedule 5</b>	Caution
<b>Schedule 6</b>	Poison
<b>Schedule 7</b>	Dangerous Poison
<b>Schedule 8</b>	Controlled Drug
<b>Schedule 9</b>	Prohibited Substance
<b>Schedule 10</b>	Substances of such danger to health as to warrant prohibition of sale, supply and use

3

4 **Controlled drugs**

5 Australia has no central body to regulate the handling of Schedule 8 drugs. Rather,  
 6 each state and territory self-regulates under the general principles established by the  
 7 federal Therapeutic Goods Administration (TGA) and has its own interpretation and  
 8 legislation regarding controlled drugs, resulting in varied requirements to ensure  
 9 legal compliance (Hua et al., 2015). Although each State and Territory is free to  
 10 interpret the SUSMP as it sees fit, the vast majority of medicines and poisons are  
 11 classified according to the SUSMP with a view to achieving uniform national  
 12 regulation.

1 In NSW, for example, the regulation of medicines, including controlled drugs, is set  
2 out in the Poisons and Therapeutic Goods Act (1966) and the associated Poisons  
3 and Therapeutic Goods Regulations (2008). It imposes limitations on the use of  
4 controlled drugs by restricting their distribution, prescription and/or administration to  
5 appropriately qualified and authorised persons.

6 In 2016, the NSW Government adopted Schedules 1 to 9 of the Poisons Standard as  
7 a replacement for its own Poisons List (Poisons and Therapeutic Goods (Poisons  
8 List) Proclamation 2016). Accordingly, all controlled drugs in NSW are as listed in  
9 Schedule 8 of the SUSMP. Each state or territory enacts its own legislation defining  
10 the requirements for storage and handling, prescriptions, labels and containers, etc.  
11 Again, there is significant similitude between these various state laws.

## 12 Discussion

13 Four of the five jurisdictions examined here maintain two separate lists – one for  
14 each of the primary remits of drug legislation – with only the US categorising drugs in  
15 a single scheduling system for both use and misuse. Of the four, the UK, New  
16 Zealand, and Canada classify drugs based on their potential for abuse for the  
17 purposes of enforcement: the latter territory having five such hierarchical schedules,  
18 while the others maintain three classes (Figure 2). These classes or schedules  
19 generally include all drugs of the same functional type (e.g. opioids, amphetamines,  
20 benzodiazepines), subject to specific exceptions. Only Australia's system of  
21 classifying drugs is entirely independent of their mechanism of action; instead  
22 specifying quantities at which increasingly serious charges may be levied for  
23 possession of each individual drug. This recognises that different drugs from within  
24 the same class may pose greatly differing levels of risk to public health through  
25 misuse, effectively creating over 350 discrete classes of drugs for the purpose of  
26 determining penalties, and statutory guidance as to which charges should be levelled  
27 in court. Elsewhere, all drugs within the same class are subject to the same  
28 penalties, and relevant circumstantial evidence including – for example – the quantity  
29 of the drug, its presentation, or the accompanying possession of drug supply  
30 paraphernalia or unexplained cash, play a significant role in what the relevant charge  
31 will be.

1 In dealing with the legitimate use of controlled drugs, there is significantly more  
2 variation between each country. While New Zealand's Misuse of Drugs Regulations  
3 do categorise drugs on the basis of decreasing management requirements, the  
4 categories are not independent of the three drug classes defined in their Misuse of  
5 Drugs Act. Rather, classes are further subdivided into parts, which are subject to  
6 decreasing regimes of control (**Table 3**). Thus, no Class C drug has more onerous  
7 controls placed on its legitimate medical use than any drug in Class B, which itself is  
8 subject to less control than Class A drugs.

9 In Australia, all Schedule 8 poisons (Controlled Drugs) from diamorphine to codeine  
10 (as a single ingredient) are subject to the same regimes of control. This schedule –  
11 containing mostly opioids, together with ketamine and two benzodiazepines which  
12 have been identified as particularly prone to misuse – maps well against Schedule 2  
13 of the UK's Misuse of Drugs Regulations. However, other drugs – including most  
14 benzodiazepines – which would be Schedules 3 or 4 CDs in the UK are classified as  
15 Prescription Only Medicines (POMs) in Australia, and therefore subject to none of  
16 the additional controls with respect to storage, record-keeping, etc. that such drug  
17 warrant in former jurisdiction.

18 Australia's lack of any additional categories between POM and controlled drug  
19 greatly reduces the subtlety and granularity afforded by the UK's five schedules of  
20 controlled drugs. It essentially runs a binary system of controls for medicines, with  
21 products subject to either all additional controls or none. The UK, in contrast, utilises  
22 a series of gradually increasing restraints with regard to record-keeping, storage,  
23 possession and supply.

24 Canada's regimes of control, although generated through three separate sets of  
25 regulations, are essentially very similar to those in force in the UK. The NCRs and  
26 Parts 1 and 2 of the FDRs contain broadly the same range of drugs as Schedules 2  
27 and 3 of the UK's MDRs, and those drugs listed in Part 3 of the FDRs and BOTSRs  
28 map well against those in Schedule 4 of the MDRs. Compound preparations  
29 containing low strengths or low doses of narcotics are treated as medicines, which  
30 are scheduled under the NDS: under UK regulations, such preparations would be  
31 Schedule 5 controlled drugs, which are subject to only very slightly stricter controls  
32 than other medicines.

1 Where a single schedule is maintained for all controlled substances based on a  
2 combination of factors from both categories – as in the US – there exists the  
3 possibility that a drug with tangible medical benefits may be placed into an  
4 unnecessarily low schedule based on a perceived potential for abuse. Diamorphine,  
5 for example, is licensed for the treatment of chronic pain in the UK, Australia, New  
6 Zealand, and Canada, but not in the US. The reputation of diamorphine (heroin) as a  
7 drug anchored in “powerful discourses of crime, death and pleasure” has seen it  
8 listed in Schedule 1 of the US’s Controlled Substance Act 1970 despite its  
9 recognition as a useful analgesic elsewhere in the world (Schepelern Johansen and  
10 Schepelern Johansen, 2015).

11 Most benzodiazepines are Class C drugs in the UK, as they have relatively little  
12 capacity for harm, and so attract more lenient punishments for offences such as  
13 possession or supply. Many benzodiazepines, such as diazepam, are widely used in  
14 medicine and are classified as Schedule 4 controlled drugs, which are subject to  
15 regimes of control only slightly more stringent than for other prescription-only  
16 medicines (POMs). In common with other benzodiazepines, flunitrazepam is a Class  
17 C drug: however, its tendency to induce anterograde amnesia in sufficient doses led  
18 to its misuse in drug-facilitated sexual assault (DFSA), resulting in it being moved to  
19 Schedule 3 in 1998 (Misuse of Drugs (Amendment) Regulations 1998; reg. 2(4)).  
20 Schedule 3 drugs are subject to more stringent regulations with regard to security  
21 (Misuse of Drugs (Safe Custody) Regulations 1973). This resulted in an additional  
22 barrier to the diversion of flunitrazepam from legitimate sources without the need to  
23 increase the punishment for its possession.

## 24 **Conclusion**

25 The benefit of maintaining two separate lists categorising the same controlled drugs  
26 is that it recognises the disparity between the two main requirements of drug  
27 legislation, namely: preventing the misuse of dangerous drugs to the detriment of  
28 society; and allowing dangerous drugs to be used for the benefit of society. Such a  
29 system allows for considerable flexibility with regard to how controlled drugs can be  
30 managed, and how failure to comply with management regimes is punished.

31 In dealing with criminal activities associated with controlled substances, Australia’s  
32 system of imposing penalties based on the quantity of a drug possessed, rather than

1 on its often-arbitrary grouping with other drugs of a broadly similar type offers the  
2 most flexibility. In terms of managing the legitimate use of such drugs, however, it is  
3 perhaps the least flexible of the four jurisdictions operating parallel systems of  
4 categorisation. The greatest level of flexibility is offered by Canada and the UK,  
5 which have functionally very similar protocols in this respect, although the latter  
6 manages to achieve the same goals using a single set of regulations compared to  
7 the former's three.

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