

Review of the UK's Drugs Classification System - a Public Consultation.

**Home Office
Crime and Drug Strategy Directorate
May 2006**

*[Note (July 2010): This a draft of a consultation paper
which was not, in fact, approved for publication in 2006.
The draft is being released under Freedom of Information
legislation.]*

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Ministerial Foreword

1.1 The current arrangement of classifying controlled drugs through a three-tier system (i.e. Class A, B and C) was established by the Misuse of Drugs Act 1971. Drugs are placed in these three classes to reflect their relative harms and the maximum penalties which offences relating to their cultivation, possession and supply attract.

1.2 Historically, there has been very little movement of drugs between the three classes since the Misuse of Drugs Act was introduced in 1971. However, the classification system, and the way in which it is operated, lacks clarity, and has led to prolonged disagreements over whether certain drugs have been classified correctly according to their relative harms. This has been particularly true in the case of cannabis, the reclassification of which from a Class B to a Class C drug in January 2004 resulted in a degree of public confusion as to the Government's view of its harmfulness and illegality.

1.3 When the Home Secretary announced his decision to retain cannabis as a Class C drug on 19 January 2006, he said that he would be reviewing the classification system operated under the Misuse of Drugs Act. This consultation paper represents the first stage of that review. It will be augmented by a series of consultation events organised by the Home Office during the consultation period. Ministers will consider the outcome very carefully before announcing a decision on the way forward in the Autumn of 2006.

1.4 To set this review in its proper context, it is worth emphasising that the patterns of drug misuse in the United Kingdom have changed markedly in the 35 years since the 1971 Act was passed in Parliament.

1.5 The Government's Drug Strategy is beginning to have a real impact in tackling drug misuse; the associated harms are now beginning to reduce. But there is much more that we need to do, including getting clear messages across about the harms that drugs cause. Having a clear and readily understood classification system on which to base messages which are realistic, relevant and credible is essential.

1.6 The misuse of drugs is a global issue that requires a concerted international response. The UK takes its international responsibilities on drugs matters very seriously and decisions taken following this consultation will be entirely consistent with those responsibilities. In other words, any new classification system which may be adopted would need to be consistent with the UK's obligations under the relevant UN Conventions.

Purpose of the Review

2.1 The UK system of classifying drugs according to their harmfulness has been in place since the introduction of the Misuse of Drugs Act in 1971. Over the past 35 years patterns of drug use have changed quite significantly, and recent debates about the classification of certain drugs, especially cannabis, have led to questions about the clarity of the current system and whether it remains fit for purpose.

2.2 Drugs are classified in order to provide direction to courts for penalties for different drugs. The classification system is in part based on a distinction between the effects and dangers of different drugs to individuals and society and between the offences of possession and supply. It also reflects international controls on illegal drugs.

2.3 The objective of this consultation is to explore alternative ways for controlled drugs to be classified so that there is a greater understanding of their harmfulness and the reasons for their illegality.

2.4 The Government's Drug Strategy sets out the policies that aim to reduce the harms caused by drugs to individuals, communities and society. It is not altogether clear to a significant proportion of people how the classification system contributes to that overall aim. We need to explain the basis for the current system before looking at some of the possibilities for change.

2.5 There is always the risk when implementing policy of unintended consequences. Establishing a class system necessarily means there will be a class of drugs deemed more harmful than the lower class of drugs. The drugs in the lower class(es) still present significant risk. However placing drugs in the lower category can be construed as the Government indicating that the drug is not very harmful and not a serious matter if possessed or used. It is important that at the end of the review it is clearly understood that every drug within the classification system presents significant harms and that possessing or supplying those drugs is a serious matter.

Scope of the Review

2.6 Under their international obligations (e.g. the UN Conventions) the vast majority of countries across the world control but do not classify drugs in the same way. The consultation will therefore also explore what lessons can be learned from international comparisons and experience.

2.7 This consultation concerns the system for classifying drugs under the Misuse of Drugs Act 1971, and the possible case for change. The scope does not extend to the specific classification of individual drugs, nor to the issue of legalisation. The Government has consistently made clear that all drugs are harmful and that those controlled under the Misuse of Drugs Act will continue to remain illegal.

Consultation

You may wish to respond to some of the basic issues in this consultation along the lines of the following questions:

- 1. Do we need a drug classification system to differentiate between the levels of harmfulness?**
- 2. If so, what should it cover in terms of both substances and objectives?**
- 3. How do we make any new system readily understood?**

Historical Background

3.1 Drug legislation in the UK has been developing since the first Dangerous Drugs Act in 1920. The principles of drug laws have been broadly the same; to drive down misuse by imposing penalties on supply and possession. Regulations are also in place to permit health professionals appropriate access to drugs that have proven medical use.

3.2 Imposing penalties on the offence of possession is intended to deter use, particularly experimentation by young people. It can be argued that the deterrent effect may not be as strong as it was in the past but illegality is still an important factor when people are considering engaging in risk taking behaviour.

3.3 Drug laws have evolved so a greater emphasis and greater penalties are imposed on those supplying drugs rather than individuals misusing them. There is general agreement that the individual who supplies drugs should be dealt with more severely than the individual who misuses drugs.

3.4 Under the Dangerous Drugs Acts of 1964 and 1967, all drug offences were treated with the same degree of seriousness. For example, cannabis and heroin possession offences attracted the same levels of penalties. Increasing pressure for reform began to build because the law did not recognise the relative harms different drugs caused and it was therefore deemed disproportionate and unfair.

3.5 The Misuse of Drugs Act 1971 sought to address the perceived inequalities by establishing a scale of harm. The Act was agreed through cross party consensus, being introduced to Parliament under a Labour Government but gaining Royal Assent in 1971 under a Conservative Government. In introducing the legislation in 1970, the Labour Home Secretary, James Callaghan, said: "The object here is to make, so far as possible, a more sensible differentiation between drugs. It will divide them according to their accepted dangers and harmfulness in the light of current knowledge and it will provide for changes to be made in the classification in the light of new scientific knowledge."

The Three Classes

3.6 The current classification system is contained in Schedule 2 to the 1971 Act and divides all the controlled drugs into 3 Classes - A, B, and C. Since the Act came into force there have been various amendments to reflect changes in the patterns of drug use, but these have largely been to incorporate new drugs as they have emerged in society or reflect the increasing harmfulness and/or misuse of existing and previously uncontrolled drugs. There have been very few instances of drugs moving between the classes following review, with Cannabis being the most obvious example. More recent changes have included the addition of GHB in 2003 and ketamine in January 2006 as

Class C drugs.

The Schedules

3.7 The Misuse of Drugs Regulations 2001 also divide controlled drugs into schedules depending on the extent of their legitimate medical use. The purpose of the schedules, which are linked to but separate from the classification system, is to set out the conditions governing the storage, administration and destruction of controlled drugs to prevent them leaking onto the illicit market. The scheduling system is explained in more detail later in this document (paragraphs 4.2 – 4.4).

The Advisory Council on the Misuse of Drugs

3.8 All changes to both the classification and scheduling systems require consultation with the Advisory Council on the Misuse of Drugs (ACMD) and Parliamentary agreement. The ACMD was also established under the 1971 Act. It is an independent non-departmental body comprising, at present, 36 experts from a variety of relevant backgrounds whose role is to advise the Government on a broad range of drug related issues.

3.9 Membership of ACMD includes expertise from the fields of police, judiciary, academics, GPs and other health care professionals such as psychiatrists, drug treatment service providers and the voluntary sector. Members are appointed by the Secretary of State in accordance with the guidance issued by the Office of the Commissioner for Public Appointments.

3.10 The ACMD has a statutory duty to keep under review the situation in the United Kingdom with respect to the misuse of drugs and to advise Ministers of the measures which they consider should be taken to deal with social problems which arise from drug misuse. In addition, the ACMD has a duty to consider any matter relating to drug dependence or misuse that may be referred to them by Ministers. The Home Secretary is obliged by law to consult the ACMD before controlling a drug, changing its classification or making regulations.

The Current Classification System and Schedules

Classification System and Penalties

4.1 The following section presents the current structure of classification. The existing three-tier classification system can be summarised in tabular form as follows, showing the main drugs within each class and the maximum penalties for possession and supply:

Class	A	B	C
Main Drugs in each class	Heroin, Cocaine (including Crack), Methadone, Ecstasy, LSD	Amphetamines, Barbiturates, Codeine	Cannabis, Benzodiazepines (Tranquilisers), GHB, Ketamine, Anabolic Steroids
Maximum Penalty for Possession	7 years plus unlimited fine	5 years plus unlimited fine	2 years plus unlimited fine
Maximum Penalty for Supply	Life plus unlimited fine	14 years plus unlimited fine	14 years plus unlimited fine

Note that the maximum penalty for the supply of Class C drugs was increased from 5 to 14 years at the same time cannabis was reclassified in January 2004. This measure ensured there would be no change to the penalty for supplying cannabis when the drug was moved from Class B to C.

Changes in classification and New Drugs

4.2 Drug Patterns are constantly changing which can lead the Government to act by amending a drug's classification or to bring a new drug under control. The initial source that signals the need for a change in law will vary. It may be prompted by a Ministerial request; it may be as a result of increased international controls by United Nations; or emerge following reports of increased prevalence or seizures from Government officials or Advisory Council members.

4.3 The Advisory Council has more recently established dedicated groups to carry out a complete analysis of a particular drug. The groups have been able to call upon expert evidence outside of the Advisory Council to better inform their discussion. The resulting report contains a recommendation on whether there should be a change to the controls on the particular drug. The Home Secretary will consider the content of the report carefully and meet with officials and other Ministers as necessary to discuss the merits of the case presented, as well as the potential repercussions of the proposals. If the Home Secretary is content overall with the recommendation there is a consultation paper issued and placed on the Home Office website so that all stakeholders have the opportunity to comment on the proposed change.

4.4 Subject to the responses from the consultation, the Government will proceed with the necessary legislative change. Changes to the Classes are carried out by the draft affirmative resolution procedure with an

order signed in Privy Council after debates in both Houses of Parliament.

The Schedules

4.5 A great many drugs which are known to be misused also have legitimate medicinal uses. Controlled drugs are also placed in schedules, contained in the Misuse of Drug Regulations 2001, which restrict their use according to their relative scientific and/or medicinal value. The schedules set out conditions governing their storage, administration and destruction.

4.6 The table below sets out the 5 schedules in order of controls.

Schedule	Control Level	Description	Drugs
1	High	No recognised medicinal use.	Ecstasy, LSD, cannabis
2	High	The most potent and harmful drugs that can be used clinically.	Heroin, Morphine, Cocaine
3	Medium	Lighter controls on storage and administration.	Buprenorphine Temazepam
4	Medium	Lighter controls on storage and administration. Lesser controls on prescription than schedule 3	Most tranquilisers, Ketamine, Steroids
5	Low	Contains very low levels of controlled drugs that can be bought over the counter	Kaolin and Morphine

4.7 The role and purpose of the schedules is far simpler than that of the classification system; the schedules' primary aim is to regulate and guide scientific and medical (i.e. legitimate) use and storage of drugs. Similarly, the basis of the schedules is also simpler, in that it is based on harm to health and medical use. The schedules thus represent a more purely medical/scientific logic than the classification system. They are considered in the context of international controls in section 7 of this paper.

What is the classification system for?

4.8 As previously stated, the classification system provides a framework on sentence length to the courts that differentiates penalties according to drug types and according to whether the offence was for possession or supply. It provides a long term, mechanism that reflects

the UK Government position on society's relationship to drugs, as well as a mechanism that can be revisited and revised.

4.9 The intention behind the existing approach was to create a system which was sensible and equitable reflecting the consensus that different drugs and different acts deserve different severity of response; for example it is generally accepted an offence of possession of cannabis should attract a lesser penalty than an offence of heroin supply.

4.10 It is important to have an enduring and stable mechanism for drug control to allow the Criminal Justice System in respect of drug offences to function effectively. Society needs reassurance that there is a coherent system in place to categorise drugs and determine the penalties for their possession and supply.

4.11 The classification system provides an established means (through Advisory Council on the Misuse of Drugs) for revisiting and revising the system to ensure it reflect present-day drug patterns. When a new drug becomes misused the Advisory Council are able to make a quick assessment of its harms and where it should fit in the classification system. This is important because new drugs come into fashion or are discovered, our understanding of medical or social harms may change, or public and political priorities may change.

4.12 Like much legislation, the drugs classification system has secondary and tertiary impacts on society, which may not be its explicit, primary aim. It can for example send a signal about the Government's vision of society and the Government's understanding and assessment of harms associated with particular drugs (related to the seriousness of the penalty). Through sentencing, and through influencing perceptions and behaviour, classification may also impact on drug use choices, by informing the decisions of dealers and users.

4.13 Such impacts will always exist and may create a tension between intended and unintended consequences. For example, the drugs classification system may be read as a reflection purely of harm ('hard' and 'soft' drugs) by young people and thus impact on their drug choices. This is an issue to be borne in mind when considering broader communication strategies in relation to drugs policy and the public.

4.14 The drugs classification system is not a simple measure of social or medical harms caused. It takes very careful analysis from a wide range of expert sources to ensure as unbiased and objective assessment as possible.

4.15 The drugs classification system is not a suitable mechanism for regulating legal substances such as alcohol and tobacco. The distinction between legal, prescription and illegal substances is not unequivocally based on pharmacology, economic or risk benefit analysis. It is also based in large part on historical and cultural precedents. A classification system that applies to legal as well as

illegal substances would conflict with deeply embedded historical tradition and tolerance of consumption of a number of substances that alter mental functioning (ranging from caffeine to alcohol and tobacco). Legal substances are therefore regulated through other means.

What is the classification system based on?

4.16 Classification is based on:

- Scientific knowledge (medical, social scientific, economic, risk assessment)
- Political and public knowledge (social values, political vision, historical precedent, cultural preference)

4.17 Historically, the current classification system grew out of a desire to see a fairer and proportionate approach to penalties for drug offences. Establishing such an approach involved consideration of existing knowledge on social and medical harms, as well as political vision and an understanding of the perceptions of the public.

4.18 Public consultation and international consultation with partners, as well as understanding and assessing risks, has become increasingly important to the review of classification. Classification is increasingly based on a combination of scientific knowledge as well as political and public knowledge. The following table sets out a range of inputs into classification

Table of knowledge inputs into classification system

Knowledge type	Comment
Scientific evidence on medical harms and risks is integrated into the drugs classification system; this is always under review, as the nature and content of scientific knowledge changes.	Integrated into classification via the ACMD
Social and economic knowledge: Understanding of the social context and complexity of social harms and risks is provided through consideration of social research generally as well as the pursuit of in-house research into the drugs problem (covers e.g. user groups, vulnerable groups, social impacts such as crime, interaction with CJS, economic costs of use and treatment). This is similarly under continuous review as the nature and content of social scientific knowledge changes.	Integrated into classification via the ACMD
Public consultation is an important mechanism for accessing and considering wider views of experts and non-experts alike, assessing core social values and consensus	Input into process through post ACMD recommendation consultations and current broader consultations with public/stakeholders
International partners' insight and experience is important source of learning from other contexts	Liaison with international officials provides input into process
Political knowledge: the expertise of politicians – an understanding of the political context, the potential long term consequences of decisions.	Integral to the process

4.19 All of these inputs to the decision-making process are important. No single form of knowledge, or rationality associated with that knowledge (for instance, that rationality associated with medical science) is sufficient on its own. Classification decisions must take account of scientific knowledge of medical harms, and social and economic evidence, as well as the insight provided by public consultation and risk assessment and the knowledge and understanding provided by the public bodies and Government departments.

How is a Drug's Harm Measured?

5.1 The Advisory Council on the Misuse of Drugs was set up under the Misuse of Drugs Act 1971 to provide independent expert advice to Government on a broad range of drugs issues. This includes the classification of drugs according to their relative harms. When considering the harmfulness of an individual drug the Advisory Council takes into account various factors including the physical harm of taking the drug on individual occasions and after prolonged use; the degree of pleasure and the drug's potential for physical and psychological withdrawal; the effects of intoxication as well as the harm to families and communities. The greater the impact a drug has on individuals and society the higher the Class within which it will fall.

Harm to the Individual User

Physical Harm: This refers to organ damage caused by the drug in question.

- **Acute:** Immediate effects on drug use, overdoses, heart attacks, psychotic episode.
- **Chronic:** Health consequences on repeated use, organ damage, mental health problems etc.
- **IV:** Should reflect the dangers of intravenous use of these drugs (if appropriate).

Pleasure: The pleasurable and reinforcing/ "addictive" dangers of the drug and therefore the propensity to craving.

Withdrawal

- **Psychological:** The need to continue to take drugs to avoid feeling of altered mood when stopping.
- **Physical:** Physical symptoms of withdrawal that predispose to continued use.

Harm to families and the Community

- **Intoxication:** Dangers due to society from the acute disinhibiting/intoxicating effects of the drug, accidents, drug driving etc.
- **Social:** Damage to social fabric caused by alterations in behaviour (especially increased criminality) due to drugs and also drug dealing.
- **Medical:** Secondary consequences of drug use, such as HIV, hepatitis.

5.2 The immediate harms to health of the individual are highly

influential to the overall harm of the drugs and there is a strong link to the class of the drug - any drug that can cause overdose will be considered very harmful. These drugs often have other longer term harms associated with prolonged use such as damaged organs and veins.

5.3 All drugs have some degree of social harm. Any drug can impair the motor functions in the brain, psychoactive drugs cause intoxication and so put the individual at risk of self-harm. This may be domestic accidents, work related injuries or road crashes from drug-driving.

5.4 Some substances, such as amphetamines and other stimulants cause aggression or mental instability and can therefore fuel violence and anti-social behaviour. Drug misuse can certainly worsen existing mental health problems, will slow recovery and often cause relapse.

5.5 A drug's pharmacology will also affect the degree to which its use is re-enforced. Heroin is a highly addictive substance and cannabis less so. Individuals often resort to crime to ensure they have sufficient supplies. For example, the Arrestee Survey for 2003/4 shows that 68% of shoplifting offences and 63% of burglaries were carried out by those who had taken heroin crack and cocaine in the last 12 months. Extreme levels of dependence on drugs such as heroin and crack cocaine can lead just a few individuals having a highly negative impact on a whole community. All drugs are associated with some degree of criminal behaviour.

5.6 The social impact of drug misuse is a significant factor in establishing the overall level of harm and consequently its classification. There are other social harms which are secondary but still highly significant in assessing the overall impact of a drug. The ACMD report "Hidden Harm: the children of problem drug users" published in 2003 revealed the extent and scale to which UK drug users' misuse impacted on their children's development and welfare for example.

5.7 When considering the different harms of a new drug of misuse and its potential for becoming controlled, the Advisory Council will consider each harm separately.

5.8 The assessment of harm is normally carried out first by the Advisory Council's Technical Committee or on occasion by a dedicated group. For example, the Council established a Ketamine group to assess the harm of that drug. Such groups are made up of a few Council members whose expertise will cover, typically, pharmacology, chemistry, treatment and social science. The groups are free to co-opt members from any field or discipline to ensure they have the full range of expertise to produce a comprehensive assessment of a drug's harm. The Technical Committee have recently been applying an individual score, effectively giving a grade of harm to each drug as part of its consideration of a drug.

5.9 Points are apportioned according to the following scale:

- 3 = major/seriousness effects
- 2 = moderate effect,
- 1 = mild effect, and
- 0 = no effect

The final overall "score" is based on points from 9 criteria and will be between 0-27. The scores themselves are subjective but discussions throughout the process with other members iron out anomalies in an attempt to provide a more objective overall assessment. Each criteria carries identical weight. It may be appropriate to lend more weight to some criteria than others, e.g. social harm.

Consultation

You may wish to respond to the issues in this consultation along the lines of the following questions:

- 4. Do we need both a classification and scheduling system, or could these be combined in some way?**
- 5. Are the harms which are measured the right ones?**
- 6. Do the harms need to be weighted?**
- 7. Do we need a clear set of criteria for measuring the harms caused by drugs?**

Legal and Socially Accepted Substances

Relationships with alcohol and tobacco

6.1 People have used substances that alter mental functioning almost since the beginning of time. Some are, or have become socially acceptable, whilst others have been made illegal. Alcohol and tobacco have a long tradition of social acceptability in the majority of countries across the world (with the obvious exception of Muslim countries in respect of alcohol, whilst tobacco is becoming less acceptable in certain countries). The production, marketing and distribution of these undoubtedly harmful substances tend to operate within a regulated regime of supply. The regulations generally aim to minimise access to children and young people determined by age (16 for tobacco, 18 for alcohol in the UK).

6.2 There are also restrictions on where it is acceptable to consume these products and there are considerable restrictions on advertising their use. Regulations are also imposed to limit strength and potency of these products recognising that access to very high strengths would be even more damaging to public health.

6.3 To many young people the regulation of tobacco and alcohol and the prohibition of drugs presents a dichotomy in terms of harm. They question why substances of considerable harm such as cigarettes and alcohol are able to be consumed relatively easily when possessing a drug like cannabis can lead to prosecution.

Alcohol

6.4 Around a quarter of the UK adult population drink above the recommended weekly guidelines, which increases the risk of causing or experiencing alcohol-related harms. The Department of Health have calculated that the cost of alcohol-related harms in England alone is up to £20bn per annum. These harms include:

- harms to health;
- crime and anti-social behaviour;
- loss of productivity in the workplace; and
- social harms, such as family breakdown.

6.5 The Department of Health estimate there are over 30,000 hospital admissions annually for alcohol dependence and up to 22,000 premature deaths per annum.

Tobacco

6.6 Although tobacco use has decreased in the UK over the last 30 years there are still 106,000 deaths in the UK caused by smoking every year (84,900 in England). Smoking costs the NHS about £1.5bn per year. Main diseases include lung cancer, bronchitis, and heart disease

6.7 Harms from tobacco are predominantly confined to the harms to

an individual's health and to some extent those around the user. The social harms to tobacco use are minimal compared to alcohol. Nicotine can induce strong dependence in individuals where they find extreme difficulty in maintaining abstinence even when the damage to health is clearly apparent.

Controls

6.8 There has not, in the UK, been any attempt to impose controls comparable to illicit drugs where it would be an offence to possess and supply alcohol and tobacco. The social acceptability of, for example, alcohol would make such controls unacceptable to the majority who use alcohol responsibly and therefore impractical. But alcohol and tobacco account for more health problems and deaths than illicit drugs. To many young people this presents problems in understanding the rationale behind controlling drugs such as cannabis and ecstasy when their misuse contributes less overall harm to society than widely available drugs such as alcohol and tobacco.

6.9 In terms of death, illegal drugs amounted to 1,388 in 2003 compared to about 20,000 for alcohol and 100,000 for tobacco.

6.10 In view of the harms presented by these substances a classification system could recognise these substances in a way which would stop short of imposing comparable controls. The creation of a system to assess the harmfulness of drugs on a more structured and transparent basis, as presented earlier in this paper could be extended to cover alcohol and tobacco but for comparative and messaging rather than control purposes. Acknowledging the harmfulness of alcohol and tobacco could allow young people to give greater credence to the message that all drugs are harmful and the less overall misuse the better for individuals, their communities and society as a whole.

6.11 This approach would allow for a more logically consistent approach to substance misuse. However most people would not want to see the drugs classification system as a mechanism for regulating legal substances such as alcohol and tobacco. If applied to legal as well as illegal substances, this would conflict with deeply embedded historical tradition and tolerance of consumption of a number of substances that alter mental functioning.

International Controls

7.1 Drugs are a global issue and it is important to be mindful of this wider context. The UK is a signatory to all three UN conventions on drug matters: the Single Convention on Narcotic Drugs of 1961, the Convention on Psychotropic Substances of 1971 and the Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988.

7.2 The Conventions are mutually supportive and apply control measures in order to ensure the availability of substances for medical and scientific purposes and to prevent their diversion into illicit channels. They also include general provisions on illicit trafficking and drug misuse. The 1961 and 1971 Conventions have greater relevance for this consultation as the 1988 Convention focuses more on precursor chemicals and drug trafficking.

- **Single Convention on Narcotic Drugs 1961.** This Convention aims to combat drug abuse by co-ordinated international action, limiting the possession, use, trade in, distribution, import, export, manufacture and production of drugs exclusively to medical and scientific purposes.
- **Convention on Psychotropic Substances 1971.** The Convention establishes an international control system for psychoactive substances such as LSD and tranquilisers.
- **Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.** This Convention provides measures against drug trafficking, including provisions against money laundering and the diversion of precursor chemicals. It also provides for international cooperation through extradition of drug traffickers, controlled deliveries and transfer of proceedings.

7.3 Narcotic drugs, such as heroin or morphine, are defined as having pain killing or stupefying qualities. Psychoactive or psychotropic substances are defined as being able to affect mental activity. Not all drugs fit neatly into one or other category, for example cannabis is listed as a narcotic but also has psychoactive effects.

7.4 Two hundred and fifty of the most misused narcotic and psychoactive substances are placed in one of five schedules according to a classification of their therapeutic value and risk of abuse and health dangers. The drugs in the schedules are listed broadly in order of their harmfulness and addictiveness. The purpose of this listing is to control and limit the use of these drugs according to a classification of their therapeutic value, risk of abuse and health dangers.

7.5 The UK schedules broadly mirror the UN scheduling arrangements. There are some difficulties in making direct comparisons as the Conventions have been arranged in different formats. The 1971 Convention is set out in 5 schedules very much resembling our own

schedules. However, the 1961 Convention contains 4 schedules. The first three contain drugs in decreasing levels of dangerousness whilst Schedule IV contains drugs upon which countries may wish to impose conditions to prevent any medical use.

7.6 There are some important similarities and differences in the way the Conventions are applied. Heroin (diamorphine) is one drug where there is international consensus on its dangerousness and potential for addiction. Countries without exception place high levels of control on it. Nearly all countries also prevent the medical use of heroin, with the exception of the UK.

7.7 All signatory countries to the United Nations Drug Conventions are expected to comply with them by imposing controls. However, individual countries can decide for themselves how to control the drugs within their own domestic legal framework. The International Community expects countries to adopt broadly comparable controls, i.e. higher controls for drugs in the higher schedules. Countries carry this out in a variety of different ways depending on their own legal system.

7.8 Drug controls and strategies in individual countries are evaluated by the International Narcotics Control Board (INCB) under the United Nations. The INCB is the independent and quasi-judicial monitoring body for the implementation of the United Nations international drug control conventions. INCB produce an annual report that sets out trends in drug use, supply and production across the world and make recommendations on what more actions should be taken to tackle drug misuse. They also monitor individual countries legal changes to ensure they do not violate the Conventions.

International Comparisons

Controls in European Union Countries

8.1 Individual countries in the EU are all signatories to the UN Conventions but take differing approaches to the classification of controlled drugs. Some EU Member States distinguish between narcotic and psychoactive substances within their domestic legislation and some combine the two in a list that is based on the drug's medicinal use or potential harm.

8.2 Some member states, including the UK, classify controlled drugs according to their relative harm in order to provide a proportionate sentencing framework for the courts. In some other countries the penalties for possessing and supplying a controlled drug will depend on the type of drug in question, while in others, the penalties relate to the activity (i.e. cultivation, possession or supply) regardless of the type of drugs involved.

8.3 Looking at these differences in a little more detail, the nature of the drug itself determines the level of penalties for drug offences in 11 EU Member States (the UK, Belgium, Spain, Ireland, Italy, Cyprus, Latvia, Luxembourg, Malta, The Netherlands and Portugal). Of these, in Latvia, Malta and Portugal the penalty is only varied in respect of drug trafficking offences, whereas in Belgium, Ireland and Luxembourg it only differs for the offence of possession of (a small amount of) cannabis for personal use.

8.4 In the remaining 14 EU Member States, the law does not recognise differences between drugs and the harms they cause. Drug offences may incur the same penalty regardless of the substance involved. Judicial authorities do, however, consider the nature of the substances, as well as the quantity and other determining factors, when sentencing through use of their discretionary powers. A more detailed breakdown of EU Member States' current arrangements is included at Annex A.

Controls in the United States

8.5 In the United States, the central drug legislation is the Controlled Substances Act 1970 which places all regulated substances into one of five schedules, based on the substances medicinal value, harmfulness and potential for abuse or addiction. The Act is described more fully at Annex B.

8.6 To summarise, Schedule I is reserved for the most dangerous drugs that have no recognised medical use, the other schedules II to IV contain drugs of decreasing in overall harm while Schedule V is the classification used for the least dangerous drugs. The Act also provides a mechanism for substances to be controlled, added to a schedule, decontrolled, removed from control, rescheduled, or transferred from one schedule to another. The criteria for considering the appropriate

schedule are enshrined in statute.

8.7 The criteria cover:

- 1) A drug's actual or relative potential for abuse;
- 2) The scientific evidence of a drug's pharmacological effect;
- 3) The state of current scientific knowledge regarding the drug or other substance;
- 4) The history and current pattern of abuse;
- 5) The scope, duration, and significance of abuse;
- 6) Risk to the public health;
- 7) A drug's psychological or physiological dependence liability;
- 8) Whether the substance is an immediate precursor of a substance already controlled.

Penalties

8.8 When considering appropriate penalties, the US courts take into account the type of drug and its schedule together with the amount of the drug seized and the criminal history of the offender. These factors are then applied as a formula through a grid system that determines the sentence the court is permitted to impose. In practice, it means that a court will first determine the drug type and amount. The range of penalties available to the court will depend on whether there were any previous convictions. It follows that an offence involving a small amount of a relatively less harmful drug such as diazepam will incur a lesser penalty than greater amounts of more harmful drugs such as heroin and when there are previous offences. The grid system for trafficking penalties is included at the end of Annex B below.

Controls in New Zealand

8.9 The key piece of drug legislation in New Zealand is the Misuse of Drugs Act 1975, which is similar to the UK's legislation in placing drugs in 3 classes. The basis for classifying drugs as either Class A, B or C was reviewed in 2000 with the aim of reducing the apparent inconsistencies in relative harms. A more detailed view of the New Zealand system is at Annex C.

8.10 A new basis for classifying controlled drugs was introduced by the Misuse of Drugs Amendment Act 2000. The Act now states that the classification of controlled drugs is based on the risk of harm that the misuse of the drug poses to individuals or society. Accordingly:

- drugs that pose a very high risk of harm are classified as Class A
- drugs that pose a high risk of harm are classified as Class B
- drugs that pose a moderate risk of harm are classified as Class C.

In 2006 the New Zealand Government added a further class - Class D - to cover Benzylpiperazines (BZPs) known as 'party pills'. The new class applies certain regulatory restrictions on their sale while research is carried out on the harms of the drug. After research is completed BZPs

may become classified as a controlled drug.

8.11 The legal changes in 2000 included the establishment of an Expert Advisory Committee on Drugs (EACD). The mandate of the EACD is to ensure that New Zealand's drug classification decisions are evidence-based, appropriate to their domestic situation, but also consistent with international obligations.

8.12 The factors that the EACD must advise the Minister on when it considers a particular substance are set in statute and include:

- likelihood or evidence of abuse, including prevalence of the drug, seizure trends and potential appeal to vulnerable populations
- specific effects of the drug, including pharmacological, psychoactive and toxicological effects of the drug
- the risk, if any, to public health
- therapeutic value of the drug, if any
- the potential for overdose
- the ability to create physical or psychological dependence
- the international classification and experience of the drug in other jurisdictions
- other matters considered relevant by the Minister
- potential presumption for supply and justification for this.

8.13 The procedure for controlling drugs is a similar process to the UK system through the Advisory Council on the Misuse of Drugs, Ministers and Parliament. When a drug is to be considered by the EACD, the first step is for officials to prepare a preliminary paper which is circulated to EACD members. The EACD then considers the paper and provides its expert advice. Final papers will then be produced which will provide the basis for the advice to the Minister of Health who decides whether or not to make a recommendation to the Governor General and Cabinet. After consultation, before any law change is made regarding the classification status of a drug, it must be approved by Parliament.

Schedules/Classes

8.14 The Act contains four Schedules - the First, Second and Third Schedules identify substances classified as controlled drugs under the Act. Schedule 4 identifies substances that are classified as precursor substances. The Act's Schedules are often referred to as Classes. The first Schedule is Class A, the second Schedule, Class B and the third Schedule is Class C.

8.15 The New Zealand system has strong parallels to the current UK system. One important similarity is the potential severity of the penalties associated with offences involving controlled drugs. Offences involving First Schedule (or Class A) drugs provide for more stringent penalties than offences involving Second Schedule (Class B) drugs and so forth.

Alternatives Systems for Consideration

9.1 This section of the consultation document provides some options for possible change. We would welcome the presentation of alternatives as well as comments on the broad ideas described here. The principal objectives in formulating or developing possible changes should be to produce an alternative to the current system which greatly enhances clarity, enables ease of application and ensures continued compliance with the UK's international obligations. The five ideas presented for consultation are as follows:

1. A Single Classification

9.2 The UK could follow the system adopted by certain other countries, such as Canada and Sweden, by moving to a single classification system. It would not distinguish between the relative harms associated with each of the drugs, nor would it attempt to prescribe the maximum penalties to be applied in respect of the cultivation, possession or supply of particular types of drug. It would be a step change in considering drugs harms by simply capturing all illegal drugs in one category where the sentencing would be entirely the responsibility of the courts.

9.3 Guidance to the courts, since 2004, has been carried out the Sentencing Guidelines Council (SGC), who frame and revise the actual sentencing guidelines. The SGC in turn rely on advice from the Sentencing Advisory Panel (SAP). The Panel's membership is made up of Judges and magistrates together with members with direct experience of the work of the Police, Prison and Probation services.

9.4 If the UK adopted a single classification then specific guidance would have to drawn up by the SGC on individual drugs – the guidance would set out the range of issues to be considered when passing sentence, including the harmfulness of the drug. Other aggravating factors would include the amounts involved, whether the offence was possession or supply related, the involvement of young or other vulnerable people, where the offence took place and relevant criminal history.

9.5 The Sentencing Advisory Panel (SAP) are not sufficiently conversant with the pharmacology and prevalence of drugs to give a comprehensive evaluation of their individual and social harms. This role would still be carried out by the Advisory Council on the Misuse of Drugs. ACMD would retain this role in assessing harms of new drugs or carrying out investigations on existing controlled drugs. There would be a considerable initial task for ACMD in looking at each controlled drug and providing a harm assessment to the SAP. The ACMD would have to liaise closely with the SAP - it would be for the SAP to draw up advice to be considered by the Sentencing Guidelines Council.

9.6 A single classification system carries the clear advantage of a strong and unequivocal message that all controlled drugs are illegal.

However leaving the penalties to the discretion of the courts risks confusion in the public's mind about relative harms if the factors influencing sentencing which go beyond the nature of the drug are not made entirely clear. For example an offence of heroin possession could potentially attract a greater sentence in one court than possession of amphetamines in another because of the range of aggravating factors which were taken into account in that case.

2. Integrating the Classification and Scheduling systems into a unified two-tier structure

9.7 An alternative option would be to combine the classification and scheduling systems and position the drugs within a two-tier structure relating to their relative harms and medicinal value (i.e. whether prescribable or not). The advantage of such a system would be that it simplified the overall structure, compared to a three tier structure at present. However mixing the relative harms of drugs and the sentencing framework with their medicinal application and administrative control arrangements could prove complex and produce an equally confusing system.

3. Move from the current three-tier to a two-tier system.

9.8 One further possibility would be to adopt a two-tier classification system by creating two classes out of the existing structure by drawing the demarcation line between the current classes B & C and adjusting the framework of penalties to reflect the relative harms of drugs above and below the new line. A two tier system would be currently in place in the Netherlands which makes a distinction between drugs of unacceptable and acceptable risk. Such a system in the UK might provide a clearer, and therefore more easily understood, gap between those drugs which cause the most significant harms (e.g. heroin and cocaine, etc) and the rest. However it could be argued it is too simple a system to cope with the wide range of harms of different drugs and might just lead to the perception that what we have are merely 'hard' and 'soft' drugs with the latter being not dangerous.

4. Group Classification

9.9 One criticism of the current system of classification is that it groups together drugs with very different properties but similar overall harms. Inevitably comparing drugs with different properties results in unending disputes about whether they can be considered of equal harm. For example, LSD is a powerful hallucinogen but presents little overall physical harm to the user. However it is classified alongside drugs with high potential for overdose such as opiates. This system could lead to a degree of confusion regarding the rationale that places these drugs together. Clarity could be provided by separating the drugs based on their pharmacology into their own individual classes rather than their overall potential for harm. For example:

Class I – Opiates include heroin

Class II - Cocaine and Crack

Class III - Hallucinogens – includes, LSD, magic mushrooms

Class IV - Amphetamines including methylamphetamine

Class V - Barbiturates

Class VI - Cannabis.

Class VII – Benzodiazepines including valium

Class VIII - Steroids.

9.10 There are some disadvantages to this approach. More classes do not necessarily mean greater transparency. It would be very difficult to devise separate penalties for each class and still maintain a clearly understood system by the public. One way around the problem would be to have the same penalties applying to various groups, for example higher penalties for opiates and hallucinogens than cannabis and steroids. However some drugs such as ecstasy and ketamine do not fit neatly into any one category. There could also be considerable dispute between individuals and organisations whether it was appropriate to place particular groups together for the purposes of determining penalties for example amphetamines and barbiturates.

5. Simple Harm Measurement System

9.11 As previously set out in this consultation, various factors are taken into account by the Advisory Council when considering a drug's overall harm including the physical harm of taking the drug in the short and long terms; the degree of pleasure derived from a drug that encourages repeated use; and the drug's potential for physical and psychological withdrawal which discourages abstinence. The social factors are also essential in assessing harms, including harm to relationships in terms of family breakdown and neglect and the harm caused to communities through crime and antisocial behaviour.

9.12 Section 5 of this consultation described the embryonic system recently introduced by the ACMD Technical Committee, where ratings are allocated to individual drugs to develop a hierarchical harm index. This system could be developed into a systematic and clear methodology, resulting in a fully rational coherent scale of harms of drugs based on the risk of the drug. This improved methodology could fit and enhance the understanding of the current three-tier system or, indeed, any alternative classification system based on hierarchical harms: for example, the two-tier system described at Option 3.

Consultation

10. If the arguments for change are accepted what model would best replace the current classification system?

11. Should a more systematic process be introduced for measuring the relative harms caused by drugs? If so, what factors should such a system take into account and how might it operate?

Application to England, Wales, Scotland and Northern Ireland

Any changes to the Classification system would apply to in England, Wales and Scotland and Northern Ireland.

Impact on Regulation

Changes to the classification system could be far reaching on its impact on the Criminal Justice system, business etc and a partial Regulatory Impact Assessment is attached.

Comments, using the attached response form should be addressed to , Drugs Legislation and Enforcement Unit, Home Office, Floor 6, Peel Building, 2 Marsham St, London SW1P 4DF.

**(E-Mail:)
by July 2006.**

A copy of this letter and attachments is also available online on the Home Office website (www.homeoffice.gov.uk). If you have any queries about this letter, please contact me on .

Consultation Response - please e-mail to

Alternatively, send by hard copy by June 2006 to:

**Drug Legislation and Enforcement Unit,
CDSD,
Floor 6,
Peel Building,
Marsham St,
London
SW1P 4DF**

From: _____

**CONSULTATION LETTER: PROPOSED CHANGES TO THE MISUSE OF DRUGS
LEGISLATION**

I have the following views on:

- * My reply may be made freely available.
- * My reply is confidential.
- * My reply is partially confidential (indicate clearly in the text any confidential elements)

Signed: _____

* Delete as appropriate

Code of Practice on Consultation

This consultation follows the Code of Practice on Consultation the criteria for which are set below.

The six consultation criteria

1. Consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of the policy.
2. Be clear about what your proposals are, who may be affected, what questions are being asked and the timescale for responses.
3. Ensure that your consultation is clear, concise and widely accessible.
4. Give feedback regarding the responses received and how the consultation process influenced the policy.
5. Monitor your department's effectiveness at consultation, including through the use of a designated consultation co-ordinator.
6. Ensure your consultation follows better regulation best practice, including carrying out a Regulatory Impact Assessment if appropriate.

The full code of practice is available at: <http://www.cabinet-office.gov.uk/regulation/Consultation/introduction.htm>

Consultation Coordinator

If you have any complaints or comments about the consultation process, you should contact the Home Office consultation coordinator by email at:

Alternatively, you may wish to write to:

Consultation Coordinator
Performance and Delivery Unit
Home Office
3rd Floor Seacole
2 Marsham Street
London SW1P 4DF

Email Disclaimer

The information you send to us may be passed to colleagues within the Home Office and/or published in a summary of responses received in response to this consultation. We will assume that you are content for us to do this, and that if you are replying by e-mail, your consent overrides any confidentiality disclaimer that is generated by your organisation's IT system. However, we will respect any wish for confidentiality that you make in the main text of your submission to us.

Annex A

Country	Main laws and lists of substances (with examples)	Classification formally determines penalty?	Application of laws
Belgium	There are two lists, in the Royal Decree of 1930 on narcotic substances (including cannabis, heroin, cocaine, codeine, methadone), and the Royal Decree of 1998 on psychotropic substances (including some amphetamines, buprenorphine, hallucinogens, MDMA).	Penalty linked to drug type for cannabis.	The package of laws and guidelines entering into force on 2 June 2003 allow a simple fine for possession of up to 3g of dried cannabis leaf or resin for personal use, without aggravating circumstances.
Czech Republic	<p>The Law no. 167/1998, On Narcotic Drugs and Psychotropic Substances, contains 11 Schedules following the UN classification, thus:</p> <p>1: UN61 Schedule I (cocaine, methadone, morphine);</p> <p>2: UN61 Schedule II (codeine);</p> <p>3: UN61 Schedule IV (cannabis, heroin);</p> <p>4: UN71 Schedule I (LSD, MDMA);</p> <p>5: UN71 Schedule II (amphetamine, buprenorphine)</p> <p>6, 7: UN71 Schedules III and IV respectively.</p> <p>8: UN61 Schedule III - narcotic preparations</p> <p>9-11: precursors</p>	Penalty not linked to drug type.	The judiciary will pass a sentence taking the type of drug into consideration.
Denmark	<p>The Executive Order 698 of 1993 on Euphoric Substances contains five lists:</p> <p>A: substances not allowed in the country (cannabis, heroin, LSD);</p> <p>B: substances used for medical and scientific purposes with substantial controls (cocaine, MDMA, amphetamines, methadone);</p> <p>C: substances which have less control as preparations (codeine);</p> <p>D: substances used for medical and scientific purposes (barbiturates,</p>	<p>Small quantities:</p> <p>Maximum and minimum penalties not linked to drug type</p> <p>Larger quantities:</p>	The actual sentencing will depend on how dangerous the drug in question is and on the amount sold or possessed.

	buprenorphine); E: substances used for medical and scientific purposes (tranquillisers).	Maximum and minimum penalties linked to drug type	
Germany	The Narcotics Act contains three lists: I: narcotic drugs not eligible for trade or prescription (heroin, cannabis, LSD, MDMA); II: narcotic drugs eligible for trade but not prescribable (delta-9-THC); III: narcotic drugs eligible for trade and prescribable (cocaine, buprenorphine, morphine, methadone).	Penalty not linked to drug type. The Narcotics Act allows for refraining from prosecution in cases involving small quantities of (any) drugs for personal use, if there is no public interest in prosecution and only minor guilt (Section 31a BtMG)	In March 1994, the Constitutional Court ruled that penal provisions for the possession of drugs are in line with the Constitution. The Court urged the Lander to assure that the provision of section 31a is applied with the greatest possible uniformity.
Estonia	The Regulation No 39 of the Minister of Social Affairs of 4 November 1997 has four schedules, plus two for precursors: I; substances generally prohibited (cannabis, heroin, LSD, MDMA) II; narcotic medicines which are dispensed only pursuant to a special medical prescription (buprenorphine, cocaine, methadone) III; narcotic and psychotropic medicines which are dispensed pursuant to a medical prescription (codeine) IV; psychotropic medicines which are dispensed pursuant to a medical prescription (diazepam)	Penalty not linked to drug type.	
Greece	The Law 1729/87 contains four lists according to the level of control: A: handling is the exclusive right of the	Penalty not linked to drug type.	According to law 2161 of 1993, the court considers the category of a substance in

	<p>State (cannabis, heroin, LSD, MDMA);</p> <p>B: handling is the right of the State Drugs Monopoly (cocaine, methadone, morphine);</p> <p>C: handling may be by licensed individuals (amphetamines, codeine);</p> <p>D: distribution may be by pharmacies (barbiturates, tranquillisers, buprenorphine).</p>		determining the sentence for a user.
Spain	The Order of 8th July 1967 and the Royal Decree 2829/1977 classify narcotic drugs and psychotropic substances, respectively, in accordance with the UN Conventions.	For personal use, penalty not linked to drug type; for trafficking, the penalties vary according to drug type.	The courts sometimes consider non-punishable even the possession of small amount of drugs not for own use, because it is not harmful for public health.
Ireland	<p>The Misuse of Drugs Regulations 1988 list five schedules based on the nature of the controls required and the usefulness of the drugs, including:</p> <p>1: cannabis, LSD, MDMA;</p> <p>2: cocaine, heroin, methadone, morphine;</p> <p>3: other psychotropic substances, (phentermine);</p> <p>4: medicaments (diazepam);</p> <p>5: specific preparations.</p>	Penalty linked to drug type for cannabis.	
Cyprus	<p>The Narcotic Drugs and Psychotropic Substances Law of 1977 lists three classes of drugs according to harm:</p> <p>Class A: methadone, morphine, MDMA, LSD, heroin;</p> <p>Class B: cannabis, codeine, some amphetamines;</p> <p>Class C: amphetamines, sedatives, benzodiazepines, buprenorphine</p>	Penalty linked to drug type.	<p>s.30 of 1977 law was amended in 2003 so that the maximum sentence for a first time offender under the age of 25 is 2 years imprisonment.</p> <p>New s.30A (2003) Introduced limits on quantities for personal use. Possession of more than that (3gr of cannabis, 10gr of cocaine or opium), creates a presumption that the person intended sale.</p>
Latvia	Cabinet Regulation N 35 adopted 20.01.2004. "Regulation on lists of controlled narcotic substances, psychotropic substances and precursors" substances are scheduled in four	For personal use, penalty not linked to drug type; for trafficking,	The penalties are not linked to the schedules, but there is an increase in maximum sentence provided for trafficking "especially

	<p>Schedules:</p> <p>Schedule I; Prohibited especially dangerous substances (cannabis, amphetamines, heroin, LSD, MDMA).</p> <p>Schedule II; Very dangerous substances permitted for medical and scientific use (cocaine, buprenorphine, methadone, morphine)</p> <p>Schedule III; Dangerous psychotropic substances which can be abused (diazepam, barbitol).</p> <p>Schedule IV; Precursor substances.</p>	the penalties vary according to drug type.	dangerous” drugs.
Lithuania	<p>The Law on the Control of Narcotic and Psychotropic Substances (January 8, 1998. No. VIII – 602 as amended) and the Order of the Minister of Healthcare of the Republic of Lithuania regarding the approval of list of narcotic and psychotropic substances (January 6, 2000 No 5 as amended) list drugs in three Schedules:</p> <p>1. Plants, narcotic and psychotropic substances prohibited for medical use, because they bring about harmful consequences to human health, when they are being misused (amphetamine, cannabis, heroin, LSD, MDMA).</p> <p>2. Plants, narcotic and psychotropic substances, used for health care purposes, which are very dangerous to human health due to the harmful consequences when these substances are misused (cocaine, codeine, methadone, morphine).</p> <p>3. Plants and psychotropic substances used for health care purposes, which are dangerous to human health due to the harmful consequences of the misuse of these substances (buprenorphine).</p>	Penalty not linked to drug type.	
Luxembourg	Three Grand Ducal Decrees of March 1974 cover narcotic drugs (such as cannabis, cocaine, heroin, methadone), psychotropic substances (LSD, MDMA) and toxic substances (amphetamine)	Penalty linked to drug type for cannabis.	Separate penalties are given for use or possession of cannabis for personal use.

	respectively.		
Hungary	<p>For penal purposes, the Hungarian Penal Code lists substances from four sources:</p> <ol style="list-style-type: none"> 1. substances in Sch I and II of UN61 2. substances in Sch I and II of UN71 3. psychotropic substances in the Schedules A (scientific use only) and B (medical use) of the Hungarian law 1998/25: medicines used by humans 4. substances in Category 1 of Annex 1 of UN88 <p>For regulatory purposes, the Governmental Order 142/2004 contains 2 lists of narcotic drugs following Sch.I and II of UN61 (and a third list about medicines not considered as drugs but their trade is subject to a drug activity permission), and 4 lists of psychotropic substances, following Schs.I-IV of UN71.</p>	Penalty not linked to drug type.	
Netherlands	<p>The Opium Act contains two lists:</p> <p>Class I: unacceptable risk (a, b, c-d):</p> <ul style="list-style-type: none"> - Ia: opiates, coca derivatives, cannabis oil; - Ib: codeine; - Ic-d: psychotropic substances; <p>Class II: others (a, b):</p> <ul style="list-style-type: none"> - IIa: tranquillisers; - IIb: cannabis. 	Penalty linked to drug type.	
Austria	<p>Two 1997 decrees list narcotic and psychotropic substances respectively.</p> <p>Narcotic drugs decree contains five schedules, containing:</p> <ul style="list-style-type: none"> - narcotic substances as listed in UN61; - psychotropic substances as listed in UN71 Schedules I and II; - other substances declared as narcotics on national level. <p>Psychotropic substances decree contains one annex, containing:</p>	Penalty not linked to drug type.	Narcotic Substances Act of 1998 introduced easier measures to waive prosecution for first-time users of cannabis

	<p>- substances listed in UN71 Schedule III (e.g., amobarbital, butalbital) or IV (e.g., allobarbital, barbital);</p> <p>- other substances declared as psychotropic substances on national level.</p>		
Poland	<p>The 1997 Act on Counteracting Drug Addiction has three appendices, each subdivided following the pattern used in the UN conventions:</p> <p>For narcotics; I-N, II-N, III-N, IV-N.</p> <p>For psychotropics; I-P, II-P, III-P, IV-P.</p> <p>For precursors; I-R, IIA-R, IIB-R.</p>	Penalty not linked to drug type.	The legislation provides for reduced sentences than the norm if the offence is of lesser gravity.
Portugal	<p>The Decree-Law 15/93 has six lists:</p> <p>I (a, b, c):</p> <ul style="list-style-type: none"> - Ia: opiates, eg heroin, codeine, methadone; - Ib: coca and derivatives, eg cocaine; - Ic cannabis and derivatives; <p>II (a, b, c):</p> <ul style="list-style-type: none"> - IIa: hallucinogens (LSD, MDMA); - IIb: amphetamines; - IIc: barbiturates, buprenorphine <p>III: specific preparations;</p> <p>IV: tranquillisers and analgesics, eg diazepam;</p> <p>V, VI: precursors.</p>	Penalty linked to drug type.	
Slovenia	<p>The Production and Trade in Illicit Drugs Act describes three groups, listed in an annex to the Order on Classification of Illicit Drugs:</p> <p>Group I – non-medical drugs, highly dangerous such as cannabis, heroin, LSD, MDMA</p> <p>Group II – medical drugs that are highly dangerous (cocaine, codeine, buprenorphine, methadone).</p> <p>Group III – medical drugs of medium danger (diazepam).</p>	Penalty not linked to drug type.	The judges have the right of discretion to define the exact penalty, including taking expert advice about the risks and danger of some specific drugs.
Slovakia	Three categories based on health impact	Penalty not linked to drug	

	<p>of the substance:</p> <p>1 – Cannabis, heroin, LSD, MDMA</p> <p>2 – Cocaine, amphetamine, methadone</p> <p>3 – buprenorphine, codeine.</p>	type.	
Sweden	<p>The Ordinance on Prohibition of Certain Goods Dangerous to Health (1999:58) lists substances under control but which are not classified as narcotics. It is common that those substances become classified as narcotic drugs after further investigation. For substances already classified as narcotic drugs, the Medical Products Agency Regulation 2000:7 has five lists.</p> <p>I: drugs without medicinal use (cannabis, heroin, MDMA, LSD);</p> <p>II: drugs with a limited medicinal use and a high risk of addiction (amphetamines, cocaine, methadone);</p> <p>III: drugs with medicinal use and a risk of addiction (codeine);</p> <p>IV: drugs with medicinal use and a low risk of addiction (barbiturates, benzodiazepines, buprenorphine).</p> <p>V: drugs prohibited in Sweden but not internationally.</p>	Penalty not linked to drug type.	The judiciary will pass a sentence taking the type of drug into consideration.
United Kingdom	<p>The Misuse of Drugs Act 1971 determines three classes for misuse, based on the level of harm caused:</p> <p>Class A: cocaine, methadone, morphine, MDMA, LSD, heroin;</p> <p>Class B: codeine, some amphetamines;</p> <p>Class C: amphetamines, cannabis, benzodiazepines, buprenorphine</p> <p>And the Misuse of Drugs Regulations 2001 denote five schedules for regulatory purposes:</p> <p>I: including cannabis, hallucinogens;</p>	Penalty Linked to Drug Type	

	<p>II: including most opiates, cocaine;</p> <p>III: including some barbiturates, some stimulants;</p> <p>IV: benzodiazepines;</p> <p>V: preparations.</p>		
Norway	<p>The Regulation of 1978 gives one alphabetical list in table format, showing the import/export requirements, whether or not the drug is banned, and any special exemptions or provisions.</p>	<p>Penalty not directly linked to drug type; except if the offence is aggravated.</p>	

The **Controlled Substances Act (CSA)** was signed into law as Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970. This statute is the legal basis by which the manufacture, importation, possession, and distribution of certain drugs are regulated by the federal government of the United States. The Act also served as national implementing legislation for the Single Convention on Narcotic Drugs.

- The legislation created five Schedules (classifications), with varying qualifications for a drug to be included in each. Two federal departments, the Department of Justice and the Department of Health and Human Services (which includes the Food and Drug Administration) determine which drugs are added or removed from the various schedules; though the statute passed by Congress created the initial listing. Classification decisions are required to be made on the criteria of potential for abuse, accepted medical use in the United States, and potential for addiction.
- The Department of Justice is also the executive agency in charge of federal law enforcement (i.e. it is the federal police force). State governments also regulate certain drugs.
- Proceedings to add, delete, or change the schedule of a drug or other substance may be initiated by the Drug Enforcement Administration (DEA), the Department of Health and Human Services (HHS), or by petition from any interested party, including the manufacturer of a drug, a medical society or association, a pharmacy association, a public interest group concerned with drug abuse, a state or local government agency, or an individual citizen. When a petition is received by the DEA, the agency begins its own investigation of the drug.
- The DEA also may begin an investigation of a drug at any time based upon information received from law enforcement laboratories, state and local law enforcement and regulatory agencies, or other sources of information.
- Once the DEA has collected the necessary data, the DEA Administrator, by authority of the Attorney General, requests from the HHS a scientific and medical evaluation and recommendation as to whether the drug or other substance should be controlled or removed from control. This request is sent to the Assistant Secretary of Health of the HHS. Then, the HHS solicits information from the Commissioner of the Food and Drug Administration and evaluations and recommendations from the National Institute on Drug Abuse, and on occasion, from the scientific and medical community at large. The Assistant Secretary, by authority of the Secretary, compiles the information and transmits back to the DEA a medical and scientific evaluation regarding the drug or other substance, a recommendation as to whether the drug should be controlled, and in what schedule it should be placed.
- The medical and scientific evaluations are binding to the DEA with respect to scientific and medical matters. The recommendation on scheduling is binding only to the extent that if HHS recommends that the substance not be controlled, the DEA may not control the substance.
- Once the DEA has received the scientific and medical evaluation from HHS, the Administrator will evaluate all available data and make a final decision whether to propose that a drug or other substance be controlled and into which schedule it should be placed.

The Drug Schedules

Schedule 1 Drugs

Findings required:

- (A) The drug or other substance has a high potential for abuse.
- (B) The drug or other substance has no currently accepted medical use in treatment in the United States.
- (C) There is a lack of accepted safety for use of the drug or other substance under medical supervision.

When it comes to a drug that is currently listed in schedule I, if it is undisputed that such drug has no currently accepted medical use in treatment in the United States and a lack of accepted safety for use under medical supervision, and it is further undisputed that the drug has at least some potential for abuse sufficient to warrant control under the CSA, the drug must remain in schedule I. In such circumstances, placement of the drug in schedules II through V would conflict with the CSA since such drug would not meet the criterion of "a currently accepted medical use in treatment in the United States." 21 USC 812(b).

Sentences for first-time, non-violent offenders convicted of trafficking in Schedule I drugs can easily turn into *de facto* life sentences when multiple sales are prosecuted in one proceeding. Sentences for violent offenders are much higher.

Drugs on this schedule include:

- GHB, Ibogaine, Cannabis, Heroin, Ecstasy, Psilocybin; 5-MeO-DIPT; MDA (3,4-methylenedioxyamphetamine), LSD, Mescaline, Peyote, Quaalude;

Schedule II drugs

Findings required:

- (A) The drug or other substance has a high potential for abuse.
- (B) The drug or other substance has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions.
- (C) Abuse of the drug or other substances may lead to severe psychological or physical dependence.

These drugs are only available by prescription, and distribution is carefully controlled and monitored by the DEA.

Drugs on this schedule include:

Cocaine, Methylphenidate (Ritalin), most pure opioid agonists, Pethidine (INN) or meperidine (USAN), fentanyl, opium, oxycodone, or morphine, short-acting barbiturates, Amphetamines, except for injectable methamphetamine.

Schedule III drugs

Findings required:

- (A) The drug or other substance has a potential for abuse less than the drugs or other substances in schedules I and II.
- (B) The drug or other substance has a currently accepted medical use in treatment in the United States.
- (C) Abuse of the drug or other substance may lead to moderate or low physical dependence or high psychological dependence.

These drugs are available only by prescription, though control of wholesale distribution is somewhat less stringent than Schedule II drugs.

Drugs on this schedule include:

Anabolic steroids; Intermediate-acting barbiturates, Ketamine, Paregoric, Xyrem, a preparation of GHB used to treat narcolepsy, Marinol, (a synthetic cannabinoid) Hydrocodone / Codeine, Rohypnol (Flunitrazepam)

Schedule IV drugs

Findings required:

- (A) The drug or other substance has a low potential for abuse relative to the drugs or other substances in schedule III.
- (B) The drug or other substance has a currently accepted medical use in treatment in the United States.
- (C) Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in schedule III.

Control measures are similar to Schedule III.

Drugs on this schedule include:

Benzodiazepines, such as alprazolam (Xanax), chlordiazepoxide (librium), and diazepam (Valium), Long-acting barbiturates such as phenobarbital; Some partial agonist opioid analgesics, such as propoxyphene (Darvon) and pentazocine (Talwin) Certain non-amphetamine stimulants, including pemoline and Modafinil.

Schedule V drugs

Findings required:

- (A) The drug or other substance has a low potential for abuse relative to the drugs or other substances in schedule IV.
- (B) The drug or other substance has a currently accepted medical use in treatment in the United States.
- (C) Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in schedule IV.

Schedule V drugs are sometimes available without a prescription.

Drugs on this schedule include:

Cough suppressants containing small amounts of codeine; preparations containing small amounts of opium or Diphenoxylate (used to treat diarrhea).

Other US provisions

The federal law has only five schedules, but some states have added a "Schedule VI" to cover certain substances which are not "drugs" in the conventional sense, but are nonetheless abused recreationally; these include toluene (found in many types of paint, especially spray paint) and similar inhalants such as amyl nitrite (or poppers), butyl nitrite, and nitrous oxide (found in many types of aerosol cans). Many state and local governments enforce age limits on the sale of products containing these substances. The states of Oregon and Iowa now require a prescription for pharmacies to dispense any cold remedy containing pseudoephedrine, due to pseudoephedrine-containing medications being widely used in the manufacture of methamphetamine. This includes many preparations which were previously available over-the-counter, such as *Sudafed* and equivalent products.

Federal Trafficking Penalties

DRUG/SCHEDULE	QUANTITY	PENALTIES	QUANTITY	PENALTIES
Cocaine (Schedule II)	500 - 4999 gms mixture	First Offense: Not less than 5 yrs, and not more than 40 yrs. If death or serious injury, not less than 20 or more than life. Fine of not more than \$2 million if an individual, \$5 million if not an individual Second Offense: Not less than 10 yrs, and not more than life. If death or serious injury, life imprisonment. Fine of not more than \$4 million if an individual, \$10 million if not an individual	5 kgs or more mixture	First Offense: Not less than 10 yrs, and not more than life. If death or serious injury, not less than 20 or more than life. Fine of not more than \$4 million if an individual, \$10 million if not an individual. Second Offense: Not less than 20 yrs, and not more than life. If death or serious injury, life imprisonment. Fine of not more than \$8 million if an individual, \$20 million if not an individual. 2 or More Prior Offenses: Life imprisonment
Cocaine Base (Schedule II)	5-49 gms mixture		50 gms or more mixture	
Fentanyl (Schedule II)	40 - 399 gms mixture		400 gms or more mixture	
Fentanyl Analogue (Schedule I)	10 - 99 gms mixture		100 gms or more mixture	
Heroin (Schedule I)	100 - 999 gms mixture		1 kg or more mixture	
LSD (Schedule I)	1 - 9 gms mixture		10 gms or more mixture	
Methamphetamine (Schedule II)	5 - 49 gms pure or 50 - 499 gms mixture		50 gms or more pure or 500 gms or more mixture	
PCP (Schedule II)	10 - 99 gms pure or 100 - 999 gms mixture	100 gm or more pure or 1 kg or more mixture		

PENALTIES		
Other Schedule I & II drugs (and any drug product containing Gamma Hydroxybutyric Acid)	Any amount	<p>First Offense: Not more than 20 yrs. If death or serious injury, not less than 20 yrs, or more than Life. Fine \$1 million if an individual, \$5 million if not an individual.</p> <p>Second Offense: Not more than 30 yrs. If death or serious injury, not less than life. Fine \$2 million if an individual, \$10 million if not an individual</p>
Flunitrazepam (Schedule IV)	1 gm or more	
Other Schedule III drugs	Any amount	<p>First Offense: Not more than 5 years. Fine not more than \$250,000 if an individual, \$1 million if not an individual.</p> <p>Second Offense: Not more 10 yrs. Fine not more than \$500,000 if an individual, \$2 million if not an individual</p>
Flunitrazepam (Schedule IV)	30 to 999 mgs	
All other Schedule IV drugs	Any amount	<p>First Offense: Not more than 3 years. Fine not more than \$250,000 if an individual, \$1 million if not an individual.</p> <p>Second Offense: Not more than 6 yrs. Fine not more than \$500,000 if an individual, \$2 million if not an individual.</p>
Flunitrazepam (Schedule IV)	Less than 30 mgs	
All Schedule V drugs	Any amount	<p>First Offense: Not more than 1 yr. Fine not more than \$100,000 if an individual, \$250,000 if not an individual.</p> <p>Second Offense: Not more than 2 yrs. Fine not more than \$200,000 if an individual, \$500,000 if not an individual.</p>

Federal Trafficking Penalties - Marijuana

DRUG	QUANTITY	1 st OFFENSE	2 nd OFFENSE
Marijuana	1,000 kg or more mixture; or 1,000 or more plants	<ul style="list-style-type: none"> • Not less than 10 years, not more than life • If death or serious injury, not less than 20 years, not more than life • Fine not more than \$4 million if an individual, \$10 million if other than an individual 	<ul style="list-style-type: none"> • Not less than 20 years, not more than life • If death or serious injury, mandatory life • Fine not more than \$8 million if an individual, \$20 million if other than an individual
Marijuana	100 kg to 999 kg mixture; or 100 to 999 plants	<ul style="list-style-type: none"> • Not less than 5 years, not more than 40 years • If death or serious injury, not less than 20 years, not more than life • Fine not more than \$2 million if an individual, \$5 million if other than an 	<ul style="list-style-type: none"> • Not less than 10 years, not more than life • If death or serious injury, mandatory life • Fine not more than \$4 million if an individual, \$10 million if other than

		individual	an individual
Marijuana	more than 10 kgs hashish; 50 to 99 kg mixture more than 1 kg of hashish oil; 50 to 99 plants	<ul style="list-style-type: none"> • Not more than 20 years • If death or serious injury, not less than 20 years, not more than life • Fine \$1 million if an individual, \$5 million if other than an individual 	<ul style="list-style-type: none"> • Not more than 30 years • If death or serious injury, mandatory life • Fine \$2 million if an individual, \$10 million if other than individual
Marijuana	1 to 49 plants; less than 50 kg mixture	<ul style="list-style-type: none"> • Not more than 5 years • Fine not more than \$250,000, \$1 million other than individual 	<ul style="list-style-type: none"> • Not more than 10 years • Fine \$500,000 if an individual, \$2 million if other than individual
Hashish	10 kg or less		
Hashish Oil	1 kg or less		

Drugs in New Zealand

First Schedule

Schedule	Part of Schedule (including general 'rules of thumb')	Examples & storage	Other sections of the Misuse of Drugs Act / Regulations	Penalties
<p>First Schedule – Class A controlled drugs: ie, drugs posing a very high risk of harm to individuals or society.</p> <p>Includes narcotic substances classified under the 1961 UN Convention and psychotropic substances classified under the 1971 Convention.</p>	<p>Severely restricted substances.</p> <p>Minister's approval required for use, except for cocaine and derivatives.</p> <p>Includes a mix of hallucinogens, stimulants, and depressants.</p>	<p>Heroin, LSD, PCP (angel dust)</p> <p>Cocaine</p> <p>Thalidomide.</p> <p>To be stored in a CD cabinet.</p>	<p>Sections 6 & 7 relate to the general prohibitions on the import, export, production, manufacture, supply, administration, or offer to supply or administer of CDs.</p> <p>S6(6) covers presumptions for supply for CDs.</p> <p>S8 provides exemptions (subject to ss 22-25) from sections 6 & 7 – eg, prescribing by medical practitioners, vets, dispensing by pharmacists etc.</p> <p>S18 - Police search and seizure without warrant.</p> <p>Regulation 3 – Minister's approval required for granting of licences to deal in CDs in the First Schedule, Part 1 of Second Schedule, and Part 1 of the Third Schedule (except for cocaine, morphine or opium and derivative compounds).</p> <p>Regulation 22 – Prohibition on supplying, administering or prescribing of CDs in the First Schedule, Part 1 or 2 of the Second Schedule and Part 1 of the Third Schedule – unless with Minister's approval.</p>	<p>Life imprisonment for the importation, manufacture or supply (subject to presumption of supply).</p> <p>Up to 14 years imprisonment for conspiracy to commit an offence.</p> <p>Up to six months imprisonment or \$1,000 fine or both for possession.</p>

Second Schedule

Schedule	Part of Schedule (including general 'rules of thumb')	Examples & storage	Other sections of the Misuse of Drugs Act / Regulations	Penalties
<p>Second Schedule – Class B controlled drugs: ie, drugs posing a high risk of harm to individuals or society.</p> <p>Includes narcotic substances classified under the 1961 UN Convention and psychotropic substances classified under the 1971 Convention.</p>	<p>Part 1 – refined or concentrated forms of cannabis (higher potency than natural plant leaf).</p> <p>Substances have generally been processed.</p> <p>Includes opiates with both therapeutic and abuse potential.</p> <p>Minister's approval only required for use of cannabis oil/resin (ie, not for morphine/opium).</p>	<p>Cannabis resin and oil (ie, hashish and hashish oil),</p> <p>Opium.</p> <p>Morphine.</p> <p>Stored in a CD cabinet.</p>	<p>S18 - Police search and seizure without warrant.</p> <p>SS 6, 7, 8 (outlined in First Schedule table above).</p> <p>Regulation 3 (outlined in First Schedule table).</p> <p>Regulation 22 (outlined in First schedule Table above).</p>	<p>Up to 14 years imprisonment for importation, manufacture or supply (subject to presumption of supply).</p> <p>Up to 10 years imprisonment for conspiracy to commit an offence.</p> <p>Up to three months imprisonment or \$500 fine or both for possession.</p>
	<p>Part 2 – mainly stimulants. Includes amphetamines with medical uses (eg, methylphenidate). Lesser dependence potential than substances in Part 1.</p> <p>Minister's approval required for prescribing, dispensing, and administration.</p>	<p>Ritalin.</p> <p>Methamphetamine.</p> <p>Dexamphetamine.</p> <p>MDMA.</p> <p>Stored in a CD cabinet.</p>	<p>Police need search warrant (S18 not applicable)</p> <p>SS 6, 7, 8 (outlined in First Schedule table above).</p> <p>Regulation 22 (outlined in First Schedule Table above).</p>	
	<p>Part 3 – commonly used for medical purposes. Lesser dependence potential than Parts 1 & 2. Includes drugs not used in NZ (yet), but have been used and classified internationally, eg, NZ asked to classify by the UN.</p>	<p>Methadone.</p> <p>Pethidine.</p> <p>Alfentanil.</p> <p>Stored in a CD cabinet.</p>	<p>Police need search warrant (S 18 not applicable).</p> <p>SS 6, 7, 8 (outlined in First Schedule Table above).</p>	

Third Schedule

Schedule	Part of Schedule (including	Examples & storage	Other sections of the Misuse of Drugs Act / Regulations	Penalties
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	general 'rules of thumb')			
<p>Third Schedule – Class C controlled drugs.</p> <p>This includes controlled drug analogues (listed in Part 7): ie, drugs posing a moderate risk of harm to individuals or society.</p> <p>Includes narcotic substances classified under the 1961 UN Convention and psychotropic substances classified under the 1971 Convention.</p> <p>Generally, narcotics in Parts 1, 2, & 3 and psychotropics in Parts 4 & 5.</p>	<p>Part 1 – natural forms of cannabis.</p> <p>Generally substances used illicitly rather than medically.</p> <p>Minister's approval required.</p>	<p>Cannabis leaf, fruit, and seed.</p> <p>Coca leaf.</p> <p>Stored in a CD cabinet.</p>	<p>S18 - Police search and seizure without warrant.</p> <p>SS 6, 7, 8 (outlined in First Schedule table above).</p> <p>Regulation 3 (outlined in First Schedule table).</p> <p>Regulation 22 (outlined in First Schedule table above).</p>	<p>Up to 8 years imprisonment for importation, manufacture or supply.</p> <p>Up to 7 years imprisonment for conspiracy to commit an offence.</p> <p>Up to three months imprisonment or \$500 fine or both for possession.</p>
	<p>Part 2 – moderate abuse potential, but also have therapeutic uses. Readily prescribed by medical practitioners.</p>	<p>Codeine powder, injection and tablet</p> <p>Some stored in a CD cabinet, others on shelf.</p>	<p>SS 6, 7, 8 (outlined in First Schedule table above).</p> <p>Police need search warrant (S 18 not applicable).</p>	
	<p>Part 3 – similar products to Part 2, ie therapeutic substances, but generally lesser dependence potential than Part 2 substances.</p> <p>Partially exempted drugs that can be supplied without prescription in certain circumstances.</p>	<p>Pholcodeine.</p> <p>Stored in a CD cabinet.</p>	<p>SS 6, 7, 8 (outlined in First Schedule table above).</p> <p>Police need search warrant (S 18 not applicable).</p> <p>Regulation 20 – supply and administration without prescription, eg in an emergency by a pharmacist if directed by a medical practitioner. Or people licensed to possess a CD under other regs (eg, hospital managers, or those in charge of aircraft or ships).</p>	

Third Schedule (continued)

Schedule	Part of Schedule	Examples	Other sections of the Misuse of	Penalties
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	(including general 'rules of thumb')	& storage	Drugs Act / Regulations	
<p>Third Schedule – Class C controlled drugs.</p> <p>This includes controlled drug analogues (listed in Part 7): ie, drugs posing a moderate risk of harm to individuals or society.</p> <p>Includes narcotic substances classified under the 1961 UN Convention and psychotropic substances classified under the 1971 Convention.</p> <p>Generally, narcotics in Parts 1, 2, & 3 and psychotropics in Parts 4 & 5.</p>	<p>Part 4 – Includes barbiturates with medical uses, eg sedative effects. Some no longer used.</p> <p>Moderate dependence / abuse potential, although barbiturates probably have more dependence / abuse potential than the benzodiazepines in Part 5 (which is why they are no longer really used).</p>	<p>Barbiturates (except ones in Part 5).</p> <p>Stored in a CD cabinet.</p>	<p>SS 6, 7, 8 (outlined in First Schedule table above).</p> <p>Police need search warrant (S 18 not applicable).</p>	<p>Up to 8 years imprisonment for importation, manufacture or supply.</p> <p>Up to 7 years imprisonment for conspiracy to commit an offence.</p> <p>Up to three months imprisonment or \$500 fine or both for possession.</p>
	<p>Part 5 – includes benzodiazepines and some barbiturates. Medical uses (eg, sedatives). Moderate risk of abuse / dependence potential. Probably less risk than Part 4 substances.</p>	<p>Benzodiazepines, eg, flunitrazepam.</p> <p>Barbiturates in combination.</p> <p>Stored in a CD cabinet.</p>	<p>SS 6, 7, 8 (outlined in First Schedule table above).</p> <p>Police need search warrant (S 18 not applicable).</p>	
	<p>Part 6 – includes pharmacy only medicines. Some over the counter.</p> <p>CDs exempted from the prohibition on export/import, supply, administer, eg, when prescribed by medical practitioners etc.</p>	<p>Specified CDs in combination where the CD cannot be readily recovered and up to stated strengths.</p> <p>eg, Codine in paracetamol.</p> <p>Stored on shelf.</p>	<p>SS 6, 7, 8 (outlined in First Schedule table above).</p> <p>See S 6(1)(a) and 8(3)(a) for the import/export exemption.</p> <p>See S83(b) for the supply and administration exemption.</p> <p>Police need search warrant (S 18 not</p>	

			applicable).	
	Part 7 - CD analogues.	Amphetamine, pethidine analogues. Stored on shelf.	SS 6, 7, 8 (outlined in First Schedule Table above). Police need search warrant (S 18 not applicable).	

Schedule 4

Schedule	Part of Schedule (including general 'rules of thumb')	Examples	Other sections of MODA	Penalties
<p>Schedule 4 – precursor substances.</p> <p>Generally should mirror the precursors in the 1988 UN Convention.</p> <p>NB: no real restrictions except agreements with industry when they export/import (eg, if Country X exports HCL to New Zealand it will notify the Ministry of Health which will advise the National Drug Intelligence Bureau).</p> <p>Memorandum of Understanding requires suppliers to record details of sales and report all sales of more than</p>	<p>Part 1 - substances with narrow uses and traded in limited volumes on the international market.</p>	Ephedrine, pseudoephedrine, lysergic acid.	S4(4)(c) the Governor-General can amend Schedule 4 to mirror any changes to the Annex to the Vienna Convention.	<p>S 12A</p> <p>Up to 7 years imprisonment or \$1000 fine, or both, for supplying, producing or manufacturing a precursor substance knowing it is to be used to commit an offence.</p>
	<p>Part 2 - substances with a wide range of uses and traded in large quantities.</p>	Hydrochloric acid,	S4(4)(c)	

90 g of amphetamine precursors eg, ephedrine and pseudoephedrine.				
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