The Controlled Substances Act (CSA) was enacted into law by the Congress of the United States as Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970.[1] The CSA is the federal U.S. drug policy under which the manufacture, importation, possession, use and distribution of certain substances is regulated. The Act also served as the national implementing legislation for the Single Convention on Narcotic Drugs.

The legislation created five Schedules (classifications), with varying qualifications for a substance to be included in each. Two federal agencies, the Drug Enforcement Administration and the Food and Drug Administration, determine which substances are added to or removed from the various schedules, though the statute passed by Congress created the initial listing, and Congress has sometimes scheduled other substances through legislation such as the Hillory J. Farias and Samantha Reid Date-Rape Prevention Act of 2000, which placed gamma hydroxybutyrate in Schedule I. Classification decisions are required to be made on criteria including potential for abuse (an undefined term),[2][3] currently accepted medical use in treatment in the United States, and international treaties.
History

In 1969, President Richard Nixon announced that the Attorney General, John N. Mitchell, was preparing a comprehensive new measure to more effectively meet the narcotic and dangerous drug problems at the federal level by combining all existing federal laws into a single new statute. The CSA did not merely combine existing federal drug laws but changed the nature of federal drug law and policy, expanded the scope of federal drug laws and expanded federal police power enormously.

Part F of the Comprehensive Drug Abuse Prevention and Control Act of 1970 established the National Commission on Marijuana and Drug Abuse—known as the Shafer Commission after its chairman, Raymond P. Shafer—to study marijuana abuse in the United States. During his presentation of the commission's First Report to Congress, Shafer recommended the decriminalization of marijuana in small amounts, saying, "[T]he criminal law is too harsh a tool to apply to personal possession even in the effort to discourage use. It implies an overwhelming indictment of the behavior which we believe is not appropriate. The actual and potential harm of use of the drug is not great enough to justify intrusion by the criminal law into private behavior, a step which our society takes only 'with the greatest reluctance.'"

Rufus King notes that this stratagem was similar to that used by Harry Anslinger when he consolidated the previous anti-drug treaties into the Single Convention and took the opportunity to add new provisions that otherwise might have been unpalatable to the international community. According to David T. Courtwright, "the Act was part of an omnibus reform package designed to rationalize, and in some respects to liberalize, American drug policy.” (Courtwright noted that the Act became, not libertarian, but instead repressionistic to the point of tyrannical, in its intent.) It eliminated mandatory minimum sentences and provided support for drug treatment and research. King notes that the rehabilitation clauses were added as a compromise to Senator Hughes, who favored a moderate approach. The bill, as introduced by Senator Dirksen, ran to 91 pages. While it was being drafted, the Uniform Controlled Substances Act, to be passed by state legislatures, was also being drafted by the Department of Justice; its wording closely mirrored the Controlled Substances Act.

Since its enactment in 1970, the Act has been amended several times:


The Domestic Chemical Diversion and Control Act of 1993.

The Federal Analog Act.

Enforcement authority

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 laboratories, state and local law enforcement and regulatory agencies, or other sources of information.

Once the DEA has collected the necessary data, the Deputy Administrator of DEA, requests from 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 HHS. Then, 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 DEA 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.

Under certain circumstances, the Government may temporarily schedule a drug without following the normal procedure. An example is when international treaties require control of a substance. In addition, 21 U.S.C. § 811(h) allows the Attorney General to temporarily place a substance in Schedule I "to avoid an imminent hazard to the public safety". Thirty days' notice is required before the order can be issued, and the scheduling expires after a year; however, the period may be extended six months if rulemaking proceedings to permanently schedule the drug are in progress. In any case, once these proceedings are complete, the temporary order is
automatically vacated. Unlike ordinary scheduling proceedings, such temporary orders are not subject to judicial review.

The CSA also creates a closed system of distribution for those authorized to handle controlled substances. The cornerstone of this system is the registration of all those authorized by the DEA to handle controlled substances. All individuals and firms that are registered are required to maintain complete and accurate inventories and records of all transactions involving controlled substances, as well as security for the storage of controlled substances.

**Treaty obligations**

The Congressional findings in 21 U.S.C. §§ 801(7), 801a(2), and 801a(3) state that a major purpose of the CSA is to "enable the United States to meet all of its obligations" under international treaties - specifically, the 1961 Single Convention on Narcotic Drugs and the 1971 Convention on Psychotropic Substances. The CSA bears many resemblances to these Conventions. Both the CSA and the treaties set out a system for classifying controlled substances in several Schedules in accordance with the binding scientific and medical findings of a public health authority. Under 21 U.S.C. § 811 of the CSA, that authority is the Secretary of Health and Human Services (HHS). Under Article 3 of the Single Convention and Article 2 of the Convention on Psychotropic Substances, the World Health Organization is that authority.

The domestic and international legal nature of these treaty obligations must be considered in light of the supremacy of the United States Constitution over treaties or acts and the equality of treaties and Congressional acts. In Reid v. Covert the Supreme Court of the United States addressed both these issues directly and clearly holding:

[N]o agreement with a foreign nation can confer power on the Congress, or on any other branch of Government, which is free from the restraints of the Constitution. Article VI, the Supremacy Clause of the Constitution, declares: "This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; . . ." There is nothing in this language which intimates that treaties and laws enacted pursuant to them do not have to comply with the provisions of the Constitution. Nor is there anything in the debates which accompanied the drafting and ratification of the Constitution which even suggests such a result. These debates, as well as the history that surrounds the adoption of the treaty provision in Article VI, make it clear that the reason treaties were not limited to those made in "pursuance" of the Constitution was so that agreements made by the United States under the Articles of Confederation, including the important peace treaties which concluded the Revolutionary War, would remain in effect. Footnote 31 It would be manifestly contrary to the objectives of those who created the Constitution, as well as those who were responsible for the Bill of Rights -- let alone alien to our entire constitutional history and tradition -- to construe Article VI as permitting the United States to exercise power under an international agreement without observing constitutional prohibitions. Footnote 32 In effect, such construction would permit amendment of that document in a manner not sanctioned by Article V. The prohibitions of the Constitution were designed to apply to all branches of the National Government, and they cannot be nullified by the Executive or by the Executive and the Senate combined. There is nothing new or unique
about what we say here. This Court has regularly and uniformly recognized the supremacy of the Constitution over a treaty. Footnote 33 For example, in Geofroy v. Riggs, 133 U. S. 258, 133 U. S. 267, it declared: "The treaty power, as expressed in the Constitution, is in terms unlimited except by those restraints which are found in that instrument against the action of the government or of its departments, and those arising from the nature of the government itself and of that of the States. It would not be contended that it extends so far as to authorize what the Constitution forbids, or a change in the character of the government, or in that of one of the States, or a cession of any portion of the territory of the latter, without its consent." This Court has also repeatedly taken the position that an Act of Congress, which must comply with the Constitution, is on a full parity with a treaty, and that, when a statute which is subsequent in time is inconsistent with a treaty, the statute to the extent of conflict renders the treaty null. Footnote 34 It would be completely anomalous to say that a treaty need not comply with the Constitution when such an agreement can be overridden by a statute that must conform to that instrument.\footnote{91}

According to the Cato Institute, these treaties only bind (legally obligate) the United States to comply with them as long as that nation agrees to remain a state party to these treaties. The U.S. Congress and the President of the United States have the absolute sovereign right to withdraw from or abrogate at any time these two instruments, in accordance with said nation's Constitution, at which point these treaties will cease to bind that nation in any way, shape, or form.\footnote{101}

A provision for automatic compliance with treaty obligations is found at 21 U.S.C. § 811(d), which also establishes mechanisms for amending international drug control regulations to correspond with HHS findings on scientific and medical issues. If control of a substance is mandated by the Single Convention, the Attorney General is required to "issue an order controlling such drug under the schedule he deems most appropriate to carry out such obligations," without regard to the normal scheduling procedure or the findings of the HHS Secretary. However, the Secretary has great influence over any drug scheduling proposal under the Single Convention, because 21 U.S.C. § 811(d)(2)(B) requires the Secretary the power to "evaluate the proposal and furnish a recommendation to the Secretary of State which shall be binding on the representative of the United States in discussions and negotiations relating to the proposal."

Similarly, if the United Nations Commission on Narcotic Drugs adds or transfers a substance to a Schedule established by the Convention on Psychotropic Substances, so that current U.S. regulations on the drug do not meet the treaty's requirements, the Secretary is required to issue a recommendation on how the substance should be scheduled under the CSA. If the Secretary agrees with the Commission's scheduling decision, he can recommend that the Attorney General initiate proceedings to reschedule the drug accordingly. If the HHS Secretary disagrees with the UN controls, however, the Attorney General must temporarily place the drug in Schedule IV or V (whichever meets the minimum requirements of the treaty) and exclude the substance from any regulations not mandated by the treaty, while the Secretary is required to request that the Secretary of State take action, through the Commission or the UN Economic and Social Council, to remove the drug from international control or transfer it to a different Schedule under the Convention. The temporary scheduling expires as soon as control is no longer needed to meet international treaty obligations.
This provision was invoked in 1984 to place Rohypnol (flunitrazepam) in Schedule IV. The drug did not then meet the Controlled Substances Act's criteria for scheduling; however, control was required by the Convention on Psychotropic Substances. In 1999, an FDA official explained to Congress:[11]

Rohypnol is not approved or available for medical use in the United States, but it is temporarily controlled in Schedule IV pursuant to a treaty obligation under the 1971 Convention on Psychotropic Substances. At the time flunitrazepam was placed temporarily in Schedule IV (November 5, 1984), there was no evidence of abuse or trafficking of the drug in the United States.

The Cato Institute's *Handbook for Congress* calls for repealing the CSA, an action that would likely bring the United States into conflict with international law, were the United States not to exercise its sovereign right to withdraw from and/or abrogate the *Single Convention on Narcotic Drugs* and/or the 1971 *Convention on Psychotropic Substances* prior to repealing the Controlled Substances Act. [10] The exception would be if the U.S. were to claim that the treaty obligations violate the United States Constitution. Many articles in these treaties—such as Article 35 and Article 36 of the Single Convention—are prefaced with phrases such as "Having due regard to their constitutional, legal and administrative systems, the Parties shall . . ." or "Subject to its constitutional limitations, each Party shall . . ." According to former United Nations Drug Control Programme Chief of Demand Reduction Cindy Fazey, "This has been used by the USA not to implement part of article 3 of the 1988 Convention, which prevents inciting others to use narcotic or psychotropic drugs, on the basis that this would be in contravention of their constitutional amendment guaranteeing freedom of speech". [12]

### Schedules of controlled substances

Placing a drug or other substance in a certain Schedule or removing it from a certain Schedule is primarily based on 21 U.S.C. §§ 801, 801a, 802, 811, 812, 813 and 814. Every schedule otherwise requires a finding specifying the "potential for abuse" before a substance can be placed in that schedule. [13] The specific classification of any given drug or other substance is usually a source of controversy, as is the purpose and effectiveness of the entire regulatory scheme.

"The term 'controlled substance' means a drug or other substance, or immediate precursor, included in schedule I, II, III, IV, or V of part B of this subchapter. The term does not include distilled spirits, wine, malt beverages, or tobacco, as those terms are defined or used in subtitle E of the Internal Revenue Code of 1986." 21 U.S.C. § 802(6) [14] Some have argued that this is an important exemption, since alcohol and tobacco are the two most widely used drugs in the United States. [15][16] More significantly the exclusion of alcohol includes wine which is sacramentally used by many major religious denominations in the United States.

Like alcohol and tobacco, the stimulant caffeine is not on the list of controlled substances. Some people[8][9][10] claim that in spite of its high prevalence, being present in coffee, tea, and many such carbonated beverages as colas, caffeine should also be included on the list. No laws to this end are known to have been proposed.
Alternatives to scheduling

Recently, in a report published in *The Lancet Journal*, researchers have introduced an alternative method for drug classification in the UK. This new system uses a “nine category matrix of harm, with an expert Delphic procedure, to assess the harms of a range of illicit drugs in an evidence-based fashion.” The new classification system suggested that alcohol and tobacco were in the mid-range of harm, while cannabis, lysergic acid diethylamide ("LSD") and MDMA ("Ecstasy") were all less harmful than the two legal drugs.\[17][18]\ This research is in line with a House of Commons of the United Kingdom report *Drug classification: making a hash of it?*.

Inconsistencies

The placement of some drugs or other substances is paradoxical: both morphine and fentanyl are in Schedule II, and heroin is in Schedule I. Fentanyl is approximately 80 times as potent as morphine, and heroin is around three times as potent as morphine. Morphine has been used by physicians for over 150 years. It is very addictive, however it is a very effective analgesic for providing relief from severe pain, so it is licensed for careful medical use. Heroin was introduced in the late 19th century and licensed the same way until it was banned in 1924.\[19]\ Fentanyl has been used for less than 50 years and has always been carefully restricted.

Schedule I controlled substances

Main article: [List of Schedule I drugs (US)](https://en.wikipedia.org/wiki/List_of_Schedule_I_drugs)

"Placement on schedules; findings required

Except ... The findings required for each of the schedules are as follows:

1. Schedule I.—
   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." \[20]\n
No prescriptions may be written for Schedule I substances, and such substances are subject to production quotas by the DEA.

Under the DEA’s interpretation of the CSA, a drug does not necessarily have to have the same abuse potential as heroin or cocaine to merit placement in Schedule I (in fact, cocaine is currently a Schedule II drug due to limited medical use):
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 in this schedule include:

- **gamma-Hydroxybutyric acid** (GHB), which has been used as a general anaesthetic with minimal side-effects and controlled action but a limited safe dosage range. It was placed in Schedule I in March 2000 after widespread recreational use. Uniquely, this drug is also listed in Schedule III for limited uses, under the trademark Xyrem;
- **12-Methoxyibogamine** (Ibogaine), which is being used successfully in curing opiate addiction (as well as alcoholism) treatment and psychotherapy in clinics in Mexico and Canada;
- **Marijuana**. Marijuana is a Schedule I drug, although controversy exists about its placement in Schedule I. There have been no reported cases of THC overdose. Main article: Removal of cannabis from Schedule I of the Controlled Substances Act.
- **Heroin** (Diacetylmorphine), which is used in some European countries as a potent pain reliever in terminal cancer patients, and as second option, after morphine. (It is about twice as potent, by weight, as morphine.)
- Other strong opiates and opioids used in many other countries, or even in the USA in previous decades for palliation of moderate to severe pain such as **nicomorphine** (Vilan), **dextromoramide** (Palfium), **ketobemidone** (Ketalgin), **dihydromorphine** (Paramorfan), **piritramide** (Dipidolor), **dicyclidihydromorphine** (Paralaudin), **dipipanone** (Wellconal), **phenadoxone** (Heptalgin) and many others.
- Weak opioids used for relief of moderate pain, diarrhea, and coughing such as **benzylmorphine** (Peronine), **nicocodeine** (Tusscodin), **Dihydrocodeinone enol acetate**. **tilidine** (Valoron), **meptazinol** (Meptid), **propiram** (Algeril), **acetyldihydrocodeine** and others.
- **Pholcodine**, a weak opioid cough suppressant with negligible abuse potential which is available over-the-counter in many other countries.
- **MDMA** (3,4-methylenedioxymethamphetamine, Ecstasy), which continues to be used medically, notably in the treatment of post-traumatic stress disorder (PTSD). The medical community originally agreed upon placing it as a Schedule III substance, but the government denied this suggestion, despite two court rulings by the DEA's administrative law judge that placing MDMA in Schedule I was illegal. It was temporarily unscheduled after the first administrative hearing from December 22, 1987 - July 1, 1988.
- **Psilocybin**, the active ingredient in *psychedelic mushrooms*;
• **5-MeO-DIPT** (Foxy / Foxy Methoxy / 5-methoxy-N,N-diisopropyltryptamine)
• **LSD** (Lysergic acid diethylamide), formerly used in psychotherapy
• **Peayote**, a cactus growing in nature primarily in northeastern Mexico; one of the few plants specifically scheduled, with a narrow exception to its legal status for religious use by members of the Native American Church;
• **Mescaline**, the main psychoactive ingredients of the peyote, san pedro, achuma, and Peruvian torch cacti;
• **Methaqualone** (Quaalude, Sopor, Mandrax), a sedative that was previously used for similar purposes as barbiturates, until it was rescheduled;
• **2,5-dimethoxy-4-methylamphetamine** (STP / DOM), a psychotropic hallucinogen that rose to prominence in 1967 in San Francisco when it appeared in pill form (known as "STP", in doses as high as four times the amounts previously considered "safe") on the black market;
• **2C-T-7** (Blue Mystic / T7), a psychotropic entheogen;
• **2C-B** (Nexus / Bees / Venus / Bromo Mescaline), a psychotropic hallucinogen and aphrodisiac;
• **Cathinone** (β-ketoamphetamine), a monoamine alkaloid found in the shrub *Catha edulis* (Kha);
• **AMT** (alpha-methyltryptamine), an anti-depressant from the tryptamine family with hallucinogenic properties; first developed in the Soviet Union and marketed under the brand name Indopan;
• **Bufotenin** (5-OH-DMT), a naturally-occurring tryptamine with hallucinogenic and aphrodisiac properties; named for the *Bufo* genus of toads whose poison contains the chemical;[24]
• **Benzylpiperazine** (BZP), a synthetic drug with a slight resemblance to MDMA and stimulant effects 10 times less potent than amphetamine (though it was mistakenly said to be 10 times more addictive than amphetamine at the drug's schedule hearing).
• **DXO**, active metabolite of Dextromethorphan, NMDA antagonist.[25]
• Controlled Substance Analogs intended for human consumption (as defined by the Federal Analog Act)

**Schedule II controlled substances**

Main article: List of Schedule II drugs (US)

"Placement on schedules; findings required

Except.... The findings required for each of the schedules are as follows:

Schedule II.—

(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." [20]

Except when dispensed directly by a practitioner, other than a pharmacist, to an ultimate user, no controlled substance in schedule II, which is a prescription drug as determined under the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 301 et seq.], may be dispensed without the written prescription of a practitioner, except that in emergency situations, as prescribed by the Secretary by regulation after consultation with the Attorney General, such drug may be dispensed upon oral prescription in accordance with section 503(b) of that Act [21 U.S.C. 353 (b)]. Prescriptions shall be retained in conformity with the requirements of section 827 of this title. No prescription for a controlled substance in schedule II may be refilled. [26] Notably no emergency situation provisions exist outside the Controlled Substances Act's "closed system" although this closed system may be unavailable or nonfunctioning in the event of accidents in remote areas or disasters such as hurricanes and earthquakes. Acts which would widely be considered morally imperative [citation needed] remain offenses subject to heavy penalties. [27]

These drugs vary in potency: for example Fentanyl is about 80 times as potent as morphine. (Heroin is roughly four times as potent.) More significantly, they vary in nature. Pharmacology and CSA scheduling have a weak relationship.

Drugs in this schedule include:

- Cocaine (used as a topical anesthetic);
- Methylphenidate (Ritalin and Concerta) & Dexamethylphenidate (Focalin) (used in treatment of Attention Deficit Disorder);
- Opium and opium tincture (laudanum), which is used as a potent antidiarrheal;
- Methadone (used in treatment of heroin addiction as well as for treatment of extreme chronic pain);
- Oxycodone (semi-synthetic opioid; active ingredient in Percocet, OxyContin, and Percodan);
- Fentanyl and most other strong pure opioid agonists, i.e. levorphanol, opium, or oxymorphone;
- Morphine;
- Mixed Amphetamine Salts under brand name Adderall;
- Lisdexamfetamine under brand name Vyvanse;
- Dextroamphetamine (Dexedrine) Dextromethamphetamine (Desoxyn);
- Hydromorphone (Dilaudid);
- Pure codeine and any drug for non-parenteral administration containing the equivalent of more than 90 mg of codeine per dosage unit.;
- Pure hydrocodone and any drug for non-parenteral administration containing no other active ingredients or more than 15 mg per dosage unit.;
- Secobarbital (Seconal);
- Pethidine (USAN: Meperidine; Demerol);
- Phencyclidine (PCP);
- Short-acting barbiturates, such as pentobarbital, Nembutal (now out of production);
- **Amphetamines** were originally placed on Schedule III, but were moved to Schedule II in 1971. Injectable **methamphetamine** has always been on Schedule II;
- **Nabilone** (Cesamet) A synthetic **cannabinoid**, an analogue to **dronabinol** (Marinol) which is a Schedule III drug.
- **Tapentadol** (Nucynta) A new drug with mixed opioid agonist and norepinephrine re-uptake inhibitor activity.

### Schedule III controlled substances

Main article: [List of Schedule III drugs (US)](https://en.wikipedia.org/wiki/List_of_Schedule_III_drugs)

"Placement on schedules; findings required

Except... . The findings required for each of the schedules are as follows:

**Schedule III.—**

(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."

Except when dispensed directly by a practitioner, other than a pharmacist, to an ultimate user, no controlled substance in schedule III or IV, which is a prescription drug as determined under the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 301 et seq.], may be dispensed without a written or oral prescription in conformity with section 503(b) of that Act [21 U.S.C. 353 (b)]. Such prescriptions may not be filled or refilled more than six months after the date thereof or be refilled more than five times after the date of the prescription unless renewed by the practitioner. Control of wholesale distribution is somewhat less stringent than Schedule II drugs. Provisions for emergency situations are less restrictive within the "closed system" of the Controlled Substances Act than for Schedule II though no schedule has provisions to address circumstances where the closed system is unavailable, nonfunctioning or otherwise inadequate.

Drugs in this schedule include:

- **Anabolic steroids** (including **prohormones** such as androstenedione);
- Intermediate-acting **barbiturates**, such as talbutal or butalbital;
- **Buprenorphine**;
- **Dihydrocodeine** single-ingredient drugs and the pure drug itself.
- **Ketamine**, a drug originally developed as a milder substitute for **PCP** (mainly to use as a human anesthetic) but has since become popular as a veterinary and pediatric anesthetic;
• **Xyrem**, a preparation of GHB used to treat narcolepsy. Xyrem is in Schedule III but with a restricted distribution system. All other forms of GHB are in Schedule I;

• **Hydrocodone / codeine**, when compounded with an NSAID (e.g. Vicoprofen, when compounded with ibuprofen) or with acetaminophen (paracetamol) (e.g. Vicodin / Tylenol 3);

• **Marinol**, a synthetic form of Tetrahydrocannabinol (THC) used to treat nausea and vomiting caused by chemotherapy, as well as appetite loss caused by AIDS;

• **Paregoric**, an antidiarrheal and anti-tussive, which contains opium combined with camphor (which makes it less addiction-prone than laudanum, which is in Schedule II;

• **Lysergic acid amide** ("LSA"), listed as a sedative but considered by some to be hallucinogenic. A precursor to and chemical relative of LSD. LSA occurs naturally in Rivea corymbosa, morning glory seeds, and Hawaiian baby woodrose seeds. LSA is not biosynthesized by the ergot fungus (Claviceps purpurea), but can be biosynthesized by other Claviceps geni. LSA can be present as an artifact in extracts of ergot.

### Schedule IV controlled substances

Main article: [List of Schedule IV drugs (US)](https://www.drugs.com/schedule-iv/)

"Placement on schedules; findings required

Except.... The findings required for each of the schedules are as follows:

Schedule IV.—

(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. Prescriptions for Schedule IV drugs may be refilled up to five times within a six month period.

Drugs in this schedule include:

• **Benzodiazepines**, such as alprazolam (Xanax), chlordiazepoxide (Librium), clonazepam (Klonopin), diazepam (Valium)
  - temazepam (Restoril) (Note that some states require specially coded prescriptions for temazepam)
  - flunitrazepam (Rohypnol) (Note that flunitrazepam is not used medically in the United States);
- The benzodiazepine-like "Z-drugs": Zolpidem (Ambien), Zopiclone, Eszopiclone, and Zaleplon;
- Dextropropoxyphene (Doloxene) and propoxyphene (sold in the U.S. as Darvon, and in combination with acetaminophen as Darvocet);
- Long-acting barbiturates such as phenobarbital;
- Some partial agonist opioid analgesics, such as pentazocine (Talwin);
- The stimulant-like drug modafinil (sold in the U.S. as Provigil) as well as its (R)-enantiomer armodafinil (sold in the U.S. as Nuvigil);
- Antidiarrheal drugs, such as difenoxin, when combined with atropine (Motofen) (difenoxin is 2-3 times more potent than diphenoxylate, the active ingredient in Lomotil, which is in Schedule V);

**Schedule V controlled substances**

Main article: List of Schedule V drugs (US)

"Placement on schedules; findings required

Except.... The findings required for each of the schedules are as follows:

Schedule V.—

(A) The drug or other substance 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."[20]

No controlled substance in schedule V which is a drug may be distributed or dispensed other than for a medical purpose. [26]

Drugs in this schedule include:

- Cough suppressants containing small amounts of codeine (e.g., promethazine+codeine);
- Preparations containing small amounts of opium or diphenoxylate (used to treat diarrhea);
- Pregabalin (Lyrica), an anticonvulsant and pain modulator.
- Pyrovalerone
- Some centrally-acting anti-diarrhoeals, such as diphenoxylate (Lomotil) when mixed with atropine to make it unpleasant for people to grind up, cook, and inject. Difenoxin with atropine (Motofen) has been moved to Schedule IV. Otherwise the drugs are in Schedule II.
Federal regulation of pseudoephedrine

Due to pseudoephedrine being widely used in the manufacture of methamphetamine (see also: pseudoephedrine, "Misuse and illicit use"), Congress passed the Methamphetamine Precursor Control Act which places restrictions on the sale of any medicine containing pseudoephedrine. That bill was then superseded by the Combat Methamphetamine Epidemic Act of 2005, which was passed as an amendment to the Patriot Act renewal and included wider and more comprehensive restrictions on the sale of pseudoephedrine containing products. This law requires customer signature of a "log-book" and presentation of valid photo ID to purchase of pseudoephedrine (PSE) containing products from all retailers.

The law restricts an individual to the retail sale of such products to no more than three packages or no more than 3.6 grams in a single transaction. Additionally, there is a limit of no more than 9 grams in one month. A violation of this statute constitutes a misdemeanor. In states where OTC medications which contain pseudoephedrine are not regulated, many retailers, notably Target and Wal-Mart have restricted their purchase by requiring it to be sold behind the pharmacy or service counter and/or placing an age restriction on purchase. Additionally, pharmacies such as CVS and Walgreens also require photo ID and log-book signatures for sales of PSE containing products in compliance with Federal law.

Prior to this, the state of Oregon passed a law requiring a prescription for pharmacies to dispense any cold remedy containing pseudoephedrine. Likewise, the states of Alabama, Arizona, Colorado, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, New Mexico, New Jersey, North Carolina, Oklahoma, Pennsylvania, Tennessee, Texas, Virginia, Washington, Wisconsin and Wyoming restrict sales of pseudoephedrine-containing products to licensed pharmacies and require customers to show photo ID and sign a log book. California, Maryland, and Maine have also enacted degrees of controlled access to over the counter drugs that contain pseudoephedrine. This affects many preparations which were previously available over-the-counter without restriction, such as Actifed, their generic equivalents, etc. California Health and Safety Code sections 11100 and 11106 specify the new restrictions regarding over the counter (OTC) sale of ephedrine or pseudoephedrine containing products (PSE).

See also
Regulation of therapeutic goods
Gonzales v. Raich
United States v. Oakland Cannabis Buyers' Cooperative
Drug-Free Workplace Act of 1988
Treaty Clause and Head Money Cases
Fair Sentencing Act

Notes
3. ^ "[D]rug abuse may refer to any type of drug or chemical without regard to its pharmacologic actions. It is an eclectic concept having only one uniform connotation: societal disapproval. ... The Commission believes that the term drug abuse must be deleted from official pronouncements and public policy dialogue. The term has no functional utility and has become no more than an arbitrary codeword for that drug use which is presently considered wrong." -- Second Report of the National Commission on Marihuana and Drug Abuse; Drug Use In America: Problem In Perspective (March 1973), p.13
5. ^ a b The 1970 Act: Don't Sit There, Amend Something
7. ^ Federal Register: August 21, 2009 (Volume 74, Number 161), Page 42220 "Under the authority vested in the Attorney General by section 201(a) of the CSA (21 U.S.C. 811(a)), and delegated to the Administrator of DEA by Department of Justice regulations (28 CFR 0.100), and redelegated to the Deputy Administrator pursuant to 28 CFR 0.104..."
8. ^ [3]
9. ^ Reid v. Covert, 354 U. S. 1 at pp 17-19
10. ^ a b [4]
11. ^ [5]
12. ^ [6]
14. ^ [7]
Appendix C: Measurement of Dependence, Abuse, Treatment, and Treatment Need - 2000 NHSDA - Substance Dependence, Abuse, and Treatment

InfoFacts - Cigarettes and Other Tobacco Products

Development of a rational scale to assess the harm of drugs of potential misuse. The Lancet (free subscription needed), http://www.thelancet.com/journals/lancet/article/PIIS0140673607604644/fulltext

Nutt, David; King, Leslie A.; Saulsbury, William; Blakemore, Colin (24 March 2007), The Lancet

History of Opioids

Government Printing Office

See United States v. Angelos, 433 F.3d 738 (10th Cir. 2006) (55 years for three sales of marijuana).

MAPS Legal History of MDMA


http://www4.law.cornell.edu/uscode/html/uscode21/uscode21_00000812----000-.html

http://www.law.cornell.edu/uscode/html/uscode21/uscode21_00000829----000-.html


http://www.doh.state.fl.us/mqa/pharmacy/info_federallaw.pdf

http://www.deadiversion.usdoj.gov/meth/index.html

External links

- Controlled Substances Act - U.S. Drug Enforcement Administration - Full text of the law, and interpretive text used as the basis of this article
- Schedules of controlled substances Code of Federal Regulations, Section 1308
- 21 USC, Chapter 13 (Cornell) - full text of the law
- 21 USC, Chapter 13 (GPO) - full text of the law
- Controlled Substances Act The schedules of the Act, with the chemical name and structure of each substance. Correlates the drugs and substances of the Act with those named in the UK Misuse of Drugs Act 1971, the Canadian Controlled Drugs and Substances Act and three United Nations treaties, the Single Convention on Narcotic Drugs, the Convention on Psychotropic Substances and the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances
- Cato Handbook for Congress, Chapter 17 "The War on Drugs".
- Statement on "Date Rape" Drugs by Nicholas Reuter, M.P.H., March 11, 1999.
- Drug Enforcement Administration, Marijuana Rescheduling Petition: Opinion and recommended ruling, findings of fact, conclusions of law and decision of administrative law judge, 6 September 1988, Section VIII, Part 16
- DEA Drug Scheduling Reference
- Combat Methamphetamine Epidemic Act 2005 (Title VII of Public Law 109-177)
- List of DEA requirements for the sale of Pseudophedrin (PSE) The Legal basis for the sale of PSE containing substances and the rules that pharmacies must follow
- Summary of DEA Requirements for PSE Sales Shorter summary for posting in workplaces

**Regulation of therapeutic goods**

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