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The Two Conjunctive Problems of Terminology and Classification in the Regulation of Addictive Substances (Drugs)

Moses Ediru
Lecturer, Faculty of Law, Benue State University, Makurdi, Nigeria

Abstract:
This work focuses on the indiscriminate use of terminologies and inadequate classification of substances (drugs) with addiction-forming and addiction-sustaining liability. To achieve its objective this work embarks on the analysis of the epithets usually deployed to describe this category of drugs, in texts and oral discourse. Particularly the definition of drug abuse is given pre-eminence and the correlation between the terminologies in use and classification fully demonstrated. Some of the findings in the work are that; (1) most of the epithets in use have fallen into oblivion; (2) there is the lack of medical characterization of strange substances abused in Nigeria. In the circumstance, this work holds the view that, "Controlled Addictive Substances" best refers to the category of drugs under consideration. Furthermore, the adoption of the relevant drug treaties requires further legislative measures to achieve meaningful drug control.

1. Introduction

Indiscriminate use of terminologies and inadequate classification of drugs liable to abuse and trafficking, which obscure the true nature of the legal regime in this area of the law, are part of the problem necessitating this work. To properly keep readers in focus, therefore, this work examines the various epithets used to refer to the drugs in question and assesses their contributions or otherwise to the development of the law in this area. In doing this, both textual and statutory definitions of the epithets are to be examined. In the place of those found to be redundant, too restrictive or inelastic in view of the growing sophistication in the illegal drug trade, this work will proffer working definitions. This work also assesses the epithets in use in oral discourse, legal treatises, and relevant disciplines and in practice. Some of the epithets to be examined in context are: dangerous drugs, narcotic drugs, psychotropic substances, controlled drugs, drug control, hard drugs and drug abuse and trafficking.

This work also considers the basis for the step-wise classification of this category of drugs, first, into narcotic drugs, psychotropic substances and substances used for the manufacture of narcotic drugs and psychotropic substances. Next, was the placement of individual drugs in the Schedules and Tables to the relevant conventions will be examined for appropriateness and consistency.

Lastly, the classification on the basis of pharmacological actions is to be x-rayed. The adequacy or otherwise of the classifications under the Nigerian, Ghanaian and US drug laws will also be assessed comparatively, and appropriate recommendations made.

2. The Problem of Terminology

In a work of this nature where terms are situated in dual context, transposed or superimposed, precision is golden. To avoid ambiguity, therefore, efforts are made to define terms contextually in relation to the underlying theme. In other words, rather than simply define the terms, medically or legally; efforts are made to relate them to the development of the law in this area. This is in recognition of the fact that some terms used to qualify drugs liable to abuse and trafficking, hamper, rather than facilitate the administration of the relevant laws.

Expectedly, as the appreciation of the drug problem increases, the need to define and re-define terms and strategies in use also increases. Invariably, there are as many epithets used to qualify drugs liable to abuse and trafficking as there are attempts at addressing the menace. Some of these epithets as used in discourses do not only obscure the true nature but also impede the efficacy of the legal regulation of substances liable to abuse and trafficking. This is because, as the illicit drug business becomes more sophisticated, most of the terms fall into oblivion for being restrictive and inelastic. It is in response to this hapless situation that this work continues the search for a more appropriate term to describe the drugs/substances in this category.

To properly understand the category of drugs that is the focus of this work, we must understand how drug abuse leads to dependence and tolerance. Drug abuse has been defined as the use, usually by self-administration of any drug in a manner that deviates from approved medical and social patterns within a given culture[i]. Gyang[ii] has defined drug abuse as, "inappropriate and unnecessary self-administration of drugs for non-medical purposes". He highlighted the main points of his definition thus:

(a) taking drug for wrong indications.
(b) taking drug for longer/shorter than medical regimen.
(c) taking drug via wrong route.
(d) talking drug at the wrong frequency.

(e) taking drug for non-medical reasons.

Both definitions underline "non-medical use" as the ingredient of drug abuse. This means that drugs liable to abuse must have been approved for medical use and that non-medical use is an abuse. In this wise, these definitions are unsatisfactory for the regulation of some addictive drugs. This is because drugs like Indian hemp, Lysergic acid diethylamide (LSD), and heroin, which are not approved for any medical use cannot be said to be abused since the term abuse means to use wrongly or to misapply. In other words, the law relating to drug abuse and trafficking prohibits the use and not the manner of use of these drugs.

Therefore, an appropriate definition of drug abuse for the purpose of regulation must not examine only the abuser's action in the interaction between the abuser and the abused drug but also the properties or characteristics of the drug. If the properties of the drug in question are not considered as in the definitions above, especially as in the highlights of Gyang's definition, then it is easy to conclude that all drugs are liable to abuse. But obviously, this is not the import of drug abuse, medically or legally. It must relate to drugs with addictive property or action.

Furthermore, "self-administration" as used in the definitions is capable of two meanings-either that the drug is administered personally by the abuser or that it is used without prescription. It would be misleading to use self-administration in the former sense since it excludes administration by another person but with the consent of the abuser. Consent here connotes voluntariness. If use without prescription is intended, then the appropriate term should be self-medication, which is the use of drugs without a doctor's prescription.

A third definition of drug abuse runs thus:

Compulsive, excessive and self-damaging use of habit forming drugs or substances, leading to addiction or dependence, serious physiological injury (such as damage to kidneys, liver, heart) and/or psychological harm (such as dysfunctional behaviour patterns, hallucinations, memory loss) or death. Also called substance abuse[iii].

With due respect, the use of habit forming drugs need not be compulsive and excessive before it can be termed drug abuse, as voluntary use even in moderation qualifies as an abuse. In other words, drug abuse must not always lead to addiction. Moreover, the resultant addiction from dependence and tolerance engenders not only adverse medical effects on the abuser but socio-economic problems to the society and even political instability of nation states.

In view of the above criticisms drug abuse can be properly defined as, "the voluntary use of medically approved and controlled addictive substances, in a manner that deviates from approved medical and social patterns within a given culture". The highlights of the proposed definition are that:

a. the administration of the drug may either be personal or by another person with the consent of the user.
b. the drug must have approved medical use.
c. the use must be contrary to approved medical and social patterns.
d. the drug must have effect on the Central Nervous System (CNS).
e. the drug must be capable of causing addiction[iv].
f. the drug must be under control.

It is in the above sense that drug abuse is used in this work. The use of drugs with the above characteristics and in the manner described ultimately leads to addiction through the processes of dependence[v] and tolerance.[5] It is the addiction, which makes it difficult for the abuser to stay off the drug that engenders the medical problems of abuse, socio-economic, psychological and even political implications. The abuser begins with non-violent street crimes such as stealing or prostitution in order to meet up with the huge financial burden of drug-addiction and may eventually graduate into violent crimes or trafficking in the drugs because of his disordered sociological and mental orientation.

Capitalizing on the predicament of the abusers, a group of greedy and unpatriotic individuals decided to make a career from the quagmire. These individuals operating as criminal organisations thrive on the huge profits from trafficking in this category of drugs; which invariably serve as the motivation. The activities of the traffickers transcend national boundaries and, therefore, call for international control mechanism. It is this group of drugs with addiction-forming and addiction-sustaining liability and, therefore, prone to abuse and trafficking that is the focus of this work.

Over the years, this category of drugs has been described with various epithets, some too restrictive and, therefore, fallen into oblivion while some are ambiguous, therefore, impeding the development of the law on the subject. It is the search for more appropriate terms that will facilitate the streamlining of the law in this area that is the concern of this work. The search begins with the definition of the term "drug" thus:

"Drug" includes any substance or mixture of substances manufactured, sold or advertised for use in:

i. the diagnosis, treatment, mitigation or prevention of any disease, disorder, abnormal physical state, or the symptoms thereof, in man or in animals;
ii. restoring, correcting or modifying organic functions in man or in animals;
iii. disinfection, or the control of vermin, insects or pests; or
iv. contraception[vi].

Also, a drug is defined as a substance that stimulates the nervous system, especially one that is addictive, for example, alcohol, cocaine or heroin[vii]. While the former merely emphasizes the process of approval for a substance to be used as a drug, the latter emphasizes the property or actions of a substance that qualifies it as a drug. Of the two definitions, the latter is more relevant to this work for its incorporation of addictive property in its definition. However, the definition suffers internal contradiction with the examples of alcohol and heroin as substances that stimulate the nervous system. Alcohol and heroin (narcotic analgesic) are essentially depressants and not stimulants. The former or statutory definition, which is inclusive and largely functional, is

unsatisfactory for our purpose for at least three reasons. First, many substances like LSD, heroin and Indian hemp are not manufactured, sold or advertised for use in any disease state yet they are categorised as drugs for the purpose of regulation. Second, in understanding drug abuse we are concerned with the adverse and not the prophylactic or curative effects of the drug. It is, therefore, submitted that the textual definition is more apt for our understanding of drug abuse since it explains the effects of the drug on the abuser. Moreover, the effects of the drug on the abuser determine the level of regulation. Third, the definition has not brought out the main characteristics of the drugs under consideration which is the capacity to act on the CNS thereby producing addiction with attendant socio-economic and psychological implications like destitution, cultism, prostitution, political thuggery, road accidents, child neglect, improvidence, among others.

The above exposition provides the basis for the assessment of the epithets under consideration thus:

a. "Dangerous drug" means:

(a) raw opium, cocoa leaves, and Indian hemp;

(b) any drug to which Part III applies at the commencement of this Act or to which the said Part may hereafter be applied under subsection (2) of section 9 or with or without modifications, under subsection (3) of section 9 of this Act[viii];

Provided that the expression shall not be deemed to include any drug mentioned in paragraph (a) where such inclusion would involve a conflict between any provision of this Part and any provision of the Indian Hemp Act.

Obviously, the term "dangerous drug" does not cover the range of substances that are today, the subject of domestic and international control. It does not cover the drugs listed for control under the Convention on Psychotropic substances of 1971 and substances frequently used for the illicit manufacture of narcotic drugs or psychotropic substances under the United Nations Conventions Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988. It is too restrictive and cannot be extended to include other drugs/substances presently listed for control, the power of the President and Commander-in-Chief to alter the list of drugs under the DDA[ix], notwithstanding. The President can only exercise his power in respect of any other drug, which if improperly used, is capable of causing ill effects substantially of the same character or nature as or analogous to those produced by morphine or cocaine[x]. In other words, he cannot stretch the term, "dangerous drug" to cover the myriads of substances which are liable to abuse and trafficking but produce ill effects dissimilar to those of morphine and cocaine. For instance, LSD, which is a hallucinogen is neither a stimulant like cocaine nor a depressant like morphine but alters mood and perception by producing satisfying dreams, free flowing ideas (ideation), amusing and abnormal/distorted sensations that are related to time, space and distance, visual and auditory hallucinations, free mixing enhanced by talkativeness, among others.

Furthermore, reference to Indian hemp as a dangerous drug under the DDA raises a serious poser. Whether, from the definition of a drug under the Foods, and Drugs Act, Indian hemp is, *stricto sensus*, a drug let alone dangerous. It should be noted that, though, Indian hemp has well over 400 pharmacological actions, it is currently not approved for any medical or social use[xi]. The lack of approval means it cannot be manufactured, sold or advertised for use as a drug. Moreover, a drug is abused only when used in a manner that deviates from approved medical or social patterns within a given culture. It is better, therefore, to refer to it as a controlled substance than a drug.

b. "Narcotic drugs": The epithet "narcotic" is used in medical and legal senses. Medically, it refers to a substance causing one to sleep or become very relaxed and feel no pain, a drug that affects the mind[xii]. This medical definition of the term "narcotic" is imprecise and, therefore, misleading. It does not specify the nature of the effects on the mind. For example, the opiates- morphine, codeine, methadone, heroin, pethidine, among others, which are the main narcotic drugs are soporific, causing pleasant drowsiness and depression. So, to say a narcotic drug affects the mind is too general. Since there are other drugs that affect the mind by stimulation and production of visual and auditory hallucinations, the definition is not specific enough for classification for the purpose of determining appropriate level of regulation. Legally, the term "narcotic" is defined as follows:

Any of the substances, natural or synthetic in the first Schedule of the Single Convention of Narcotic Drugs 1961 and the Convention as amended by the 1972 Protocol amending the Single Convention on Narcotic Drugs, as amended in the Second Schedule to this Act, including the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988[xiii].

The problem with the legal definition is that it has ignored the technical meaning with which the term "narcotic" is clothed in medicine. This is because, for a drug to qualify as a narcotic drug, it must be soporific with depressing effect on the mind. But cannabis (Indian hemp) and cocaine are listed as narcotic drugs[xiv]. Cocaine, though a pain-killer is not soporific. Cannabis is neither soporific nor a pain-killer. Cocaine, is in fact, a stimulant, which causes instant, intense and short-lived euphoria while cannabis alters perception thereby causing euphoria and exaltation.

The implication of lumping Indian hemp, opiates and cocaine together as narcotic drugs without regard to their varying potentials for abuse, the degree of the effects on the CNS, the level of acceptability and safety in medical use is that they are all liable to the same degree of regulation under the Convention on Narcotic Drugs, 1961. This is obviously undesirable since in the management and rehabilitation of addicts, the characteristics of the drug in question are vital. Moreover, the degree of addiction, the modality of treatment, the withdrawal symptoms as well as the success rate in rehabilitation are predicated on the characteristics of the individual drug. All these are factors to be considered in determining the appropriate sanctions for the abuse of individual drugs. The legal definition of narcotics to include opiates, cocaine and Indian hemp, which differ in their actions on the CNS, both in propensity and intensity of addiction is misleading for the purpose of regulation. It is submitted, that lumping all three drugs under narcotics ignores the medical basis for control and, *a fortiori*, blurs the appropriate degree of legal regulation for each drug.

Granted, it was the importation of opium, a narcotic drug, into China in the mid-19th Century by foreign Western traders that engendered the first international action on drug abuse and trafficking. Therefore, when it became necessary to apply legal strictures, the term "narcotic" readily became a convenient label for all drugs with addiction-forming and addiction-sustaining liability. But when

assorted substances became liable as well, the need for a better and clearer terminology and classification arose. In response, the United States (US), since 1971 adopted the term, "controlled substances" instead. It has also defined "narcotic drugs" to exclude cannabis, which it has listed as a hallucinogenic substance[xv]. It is submitted that the US deployment of terms reveals a better appreciation of the drug problem and should be adopted by Nigeria.

The National Assembly makes Nigeria's lack of understanding of the terms relating to addiction-forming substances manifest. Among the standing committees of the National Assembly, is the Committee on Drugs, Narcotics and Financial Crimes. The term narcotic, if used in this sense it is akin to saying, "a Committee of the Senate and the National Assembly of Nigeria". This is ridiculous, you may say. That the Nigeria formal source of law does not know that narcotics are drugs smacks of legislative incompetence.

c. "Psychotropic Substances": The term refers to substances that exert specific effects upon the brain cells[xvi], otherwise known as the CNS. Drugs used in the treatment of psychiatric disorders as well as psychotoxic agents are often collectively called psychoactive or psychotropic[xvii]. Statutorily, "psychotropic substances" means any substance, natural or synthetic or any natural materials specified in schedules I, II, III & IV of the Convention on Drugs or Psychotropic Substances[xviii], 1971. But the use of psychoactive or psychotropic substances to refer to the group of drugs under consideration (drugs with addiction-forming and addiction sustaining liability) is misleading for at least two reasons. First, it suggests that all substances with actions on the CNS are under the group and are, therefore, subject to the same degree of control. Notably, however, drugs like the anticholinergics, levodopa for Parkinson's disease, among others, act on the CNS but are not addiction-forming. They are therefore, psychoactive or psychotropic properly so-called but are not under control as such.

Second, a substance may both be psychoactive and addiction-forming like alcohol, cigarette (nicotine) or caffeine, yet, it is not subjected to any meaningful control like others for either social or other compelling reasons. Unfortunately, while the Controlled Substances Act[xix] (CSA) of the US defined "controlled substances" to exclude distilled spirits; wine, malt beverages or tobacco, the Nigerian Law on drug abuse is mute on the matter. Its muteness has raised the question of the competence of the National Drug Law Enforcement Agency (NDLEA) to regulate these substances.

Therefore, this work submits that in defining psychotropic or psychoactive substances for the purpose of regulation, distinction must be made between those with the capacity to cause addiction and those that do not have addiction-forming and addiction- sustaining liability. Furthermore, such definition must exclude substances like alcohol, cigarette (nicotine), or caffeine with the capacity to cause addiction but for social or other compelling reasons are not under any meaningful control. Once these factors are considered in defining psychotropic substances, the jurisdiction of the NDLEA becomes clear.

d. "Controlled drugs": This term, which is of scanty textual and statutory use, is often employed in oral discourse. To a trained mind (pharmaceutical and/or legal), the term is vague. It suggests that certain drugs are not controlled, whereas, in fact, all drugs are under control. What differs is the mode and degree of control to which all drugs are subjected. Drugs with only medical untoward effects have their control embedded in the ethics of the profession authorised to handle them. This is largely reflected in the dispensing requirements for the various categories of drugs listed in the Poison and Pharmacy Act[xx] (PPA). The breach of these requirements may attract legal sanctions or may be treated as professional misconduct, depending on the circumstances.

But where the adverse, untoward or side effects of a group of drugs, apart from the medical problems give rise to serious socio-economic and political implications through the process of addiction, then special control is necessary. If used in this sense, then "controlled addictive drugs" is to be preferred to "controlled drugs". The suggested epithet is more apt for at least two reasons. First, it accords with the position that not all addictive drugs are under control. Second, its use indicates that the control of a particular category of drugs is intended. No doubt, the use of "controlled addictive drugs" directs one's attention to drugs within the competence of the NDLEA, which is the focus of this work.

e. "Drug control" as used in "Regional Academy for Drug Control, Jos". The caption of this academy, established pursuant to the 1961 Convention[xxi] is misleading in several respects. First, it is suggestive of drug control in a general sense instead of control limited to drugs with addiction-forming and addiction-sustaining liability that reflects the mandate given to the Agency. Second, the use of "drug control" in this sense blurs the zones of competence of the NDLEA and NAFDAC as it may even suggest that NAFDAC officials are trained by the Academy. It is submitted, that "Regional Academy for Controlled Addictive Substances" is a more appropriate caption for the Academy. Third, the caption appears to exclude substances, which do not qualify as drugs but are *intra vires* the Agency's mandate.

f. "Hard Drugs": The term as used in the NDLEA Act[xxii] is not defined. However, it is textually used in contradistinction to soft drugs to mean drugs with very strong, often dangerous effects, which can cause a person to become addicted[xxiii]. The epithet, "hard" reveals the two main characteristics of the drugs in the group under consideration; the tendency to cause serious medical and socio-economic problems and the addiction-forming propensity.

One of the limitations of this term "hard drugs" is that there are substances with these characteristics but do not qualify to be called drugs. Moreover, the term as used in the Long Title to the NDLEA Act suggests that soft drugs are not within the contemplation of the law, whereas, Indian hemp and its derivatives (soft drugs) are regulated by the NDLEA Act. This conflict between the Long Title and the contents of the NDLEA Act smacks of legislative incompetence, which has obscured the true nature of the legal regime on drug abuse and trafficking. However, since the contents of a document or legislation supercedes its heading or Long Title, the definition of hard drugs under the NDLEA Act is wider than the textual definition because it includes drugs with dangerous effects as well as soft drugs (Indian hemp). Thematically, this definition of hard drugs accords with the position taken by this work.

g. "Drug abuse and trafficking": This is a medico-legal term of inextricable parts. The medical (drug abuse) and legal (trafficking) parts of the term are like the two sides of a coin. The nexus here is that a drug trafficker has high propensity to abuse the drugs he

traffics in for several reasons. First, the availability of the drug. Second, to supply the Dutch-courage needed for the illicit trade. Third, perhaps to ascertain the potency of the drug.

On the other hand, a person who abuses drugs, because of his disordered, sociological, psychological and mental orientation, is easily swayed into trafficking in them. In most cases this is to enable him meet up with the huge financial burden of drug dependence. But for the restrictive nature of the word "drug" in the term, it is obviously the most appropriate term to describe the drugs under consideration. Its use ignores the fact that substances, which do not qualify as drugs, are also abused. Volatile substances like gasoline, rubber solution, nail polish remover, kerosene, correction fluids are in this category, others include alcohol, nicotine (tobacco), caffeine.

From the foregoing analysis, it would appear that of all the epithets considered, "controlled substances" as used by the US and "drug abuse and trafficking" adequately conceptualize the subject under consideration. But as already noted, these have their own shortcomings. The US CSA[xxiv] has listed some drugs as controlled substances giving the impression that these drugs are the only ones under control. This is against the known fact that all drugs whether of the category contemplated by the CSA or not, are subject to one form of control or the other. To this end, the term "controlled substances" as used in the CSA is unsatisfactory for not revealing the category of drugs under control. On the other hand, "drug abuse and trafficking" when used excludes substances with addiction-forming and addiction-sustaining liability, which are not drugs. It is submitted, therefore, that the most appropriate term to conceptualize the subject is "Controlled Addictive Substances" (CAS) and the Nigerian law on it be short titled, "Controlled Addictive Substances Act" (CASA) and in correlation, "Drug Abuse and Trafficking" becomes "Substance Abuse and Trafficking".

3. Classification of Controlled Addictive Substances

By virtue of the domestication by the NDLEA Act[xxv], of the international conventions on substance abuse and trafficking, it has also adopted the classification there under. The classification is as follows:

(a) Narcotic drugs listed in Schedules I, II, III & IV of the 1961 Convention.
(b) Psychotropic substances listed in Schedules I, II, III, and IV of the 1971 Convention.
(c) Substances used for the illicit manufacture of narcotic drugs and psychotropic substances (immediate precursors) listed under Tables I and II of the 1988 Convention.

Granted, they all act on the Central Nervous System (CNS) and have addiction-forming and addiction-sustaining liability. But since they act on different sites of the CNS and are structurally dissimilar, pharmacological actions remain the only plausible criterion for their classification for legal control. However, only a cursory look at the classification of substances liable to abuse and trafficking based on their actions on the CNS is considered here so as not to derail from the focus of this work. Principally, substances used for subjective purposes are classified into:

a. Narcotic Analgesics: These are substances, which produce abnormally deep sleep with profound respiratory depression.

Examples: coagulated juice of the Poppy plant known as Papaver somniferum with morphine as the principal alkaloid, codeine and heroin as natural analogs, pethidine, methadone and fentanyl as synthetic derivatives.

Pharmacological Actions: potent analgesia (loss of pain perception), euphoria, drowsiness, brain suppression of cough, withholding of urine in the body.

Withdrawal Symptoms: extreme states of nervousness, anxiety, sleeplessness, yawning and sweating, pupil enlargement, goose skin, muscle twitching, vomiting, diarrhoea, hypertension, a strong desire to secure a "fix".

b. Substances that Alter Perception

Examples – cannabis (Indian hemp), LSD (Lysergic acid diethylamide).

Pharmacological Actions: euphoria, exaltation, ideation, visual and auditory hallucinations, alteration of time perception.

Withdrawal Symptoms: intensification of colours, distortion of shapes and spatial position, animation of non-living (inanimate) objects, bizarre ideas, notions of persecution, feeling of self pity and dejection, intermittent bout of crying, tearing, laughter or even complete dulling of emotional feelings.

c. Stimulants: These are substances, which excite or increase functions in the body.

Examples: amphetamine, cocaine, nicotine, xanthines from beverages,
coffee, tea.

Pharmacological Actions: local anesthesia (cocaine), mild to potent euphoria (depending on agent), alleviation of tiredness, feeling of confidence (false). Nicotine causes cancer, tuberculosis and heart failure.

Withdrawal symptoms: depression, suicidal urge, irregular/disturbing sleep patterns, and serious loss of appetite.

d. Depressants: These substances cause emotional disorders characterised by feelings of profound sadness.

Examples: benzodiazepines (librium, valium, ativan, lexotan, mogadon, among others), barbiturates (phenobarbitone, talbutal, secobarbital, among others), alcohol, tranquillizers (largactil).

Pharmacological Actions: induce sleep (sedation), hypnosis, anesthesia in high doses and sedative action as an adjunct in the treatment of hypertension. Tranquillizers are used to eliminate anxiety and nervousness in psychosis.

Withdrawal Symptoms – Insomnia, frightening emotional clefts, restlessness.

e. Miscellaneous Agents

Examples: anabolic steroids (athletes and sports men), nitrates (poppers"), volatile substances (petrol, glue, industrial solvents, kerosene, among others).

Pharmacological Actions: increase muscularity, sexual drive, promotes orgasm. Nitrates are used in angina pectoris and other heart diseases.

The division of psychoactive substances into narcotics[xxvi], psychotropics[xxvii] and immediate precursors[xxviii] under the international conventions as adopted by the NDLEA Act tends to ignore these pharmacological actions. Apart from the fact that drugs, which neither induce sleep nor cause a person to relax are listed as narcotic drugs, the medical basis for further grouping into Schedules I, II, III and IV is not disclosed. So too, the degree of control for drugs in each Schedule is not stated. As regards the 1971 Convention, some substances with both addiction-forming and addiction-sustaining liability and actions on the CNS are not listed under its Schedules.

Also, the medical basis for further grouping into Schedules I, II, III and IV and the degree of control of individual psychotropic substances are unknown. Unlike Nigeria which adopted these international conventions, Ghana and the US re-enacted them and created their schedules based on their local assessment of the individual drugs. In the US, for example, the provisions of the CSA[xxix] on factors determinative of control or removal from schedules, the Attorney-General is mandated to consider the following factors with respect to each drug or other substances proposed to be controlled or removed from the schedules.

1. Its actual or relative potential of abuse.
2. Scientific evidence of its pharmacological effect, if known.
3. The State of current scientific knowledge regarding the drug or other substance.
4. Its history and current pattern of abuse.
5. The scope, duration, and significance of abuse.
6. What, if any, risk there is to the public health.
7. Its psychic or physiological dependence liability.
8. Whether the substance is an immediate precursor of a substance already controlled under this subchapter.

However, the classification of substances liable to abuse and trafficking as adopted by the NDLEA Act is of legal significance. The substances in each class are regulated by different international conventions based on when the abuse and trafficking in them became a threat to the international community. In other words, propinquity was of the essence not the specific pharmacological actions of the individual substance. It is submitted that any mode of classification that ignores the pharmacological actions of the substance cannot provide a sound basis for legal regulation. This is because the specific pharmacological actions of the individual substance on the CNS are related to the propensity for addiction, which in turn determines the level of legal strictures to be applied.

The implication of adopting relevant conventions instead of re-enacting them is that they apply in Nigeria without modification. By extension, only the substances listed in the Schedules and Tables to the conventions are under control in Nigeria. This leaves Nigeria with no power to add, delete or transfer substances from one Schedule or Table to another except with the authority of the Commission on Narcotic Drugs (CND)[xxx]. Since the alteration by the Commission is to apply in all the countries that are signatories to the Conventions, information furnished by Nigeria in respect of such alternation may be insufficient for it to act. Where the information is in respect of a substance not yet listed in any of the Schedules or Tables, its abuse will continue unabated. In fact, this is the situation with the abuse of strange substances like zakamin, madara sukurdai, goscolo in Nigeria today. These substances are yet to be characterised medically for regulation and so no criminal trials can be sustained for their abuse because of the requirement of forensic investigation in drug trials. Once it cannot be established by laboratory analysis that the suspected substance is one prohibited by the law there is no case; hence, medical characterization and legislatures measures are required.

However, in re-enacting and creating new Schedules from the international conventions, Ghana and the US also provided for both procedures and the authority to alter the schedules in their respective drug laws. The Provisional National Defence Council Secretary responsible for the interior may by legislative instrument amend the Schedules to the Law[xxxi]. In the case of the US, the power to add, delete or transfer substances from one Schedule to another is vested in the Attorney-General by the CSA[xxxii].

For proper classification of controlled addictive substances therefore, Nigeria should create schedules under the NDLEA Act and designate the authority to alter the schedules when ever necessary. This is the only way it can resolve the dilemma of the abuse of medically uncharacterised substances having regard to their pharmacological actions on the CNS.

As a result, the US had since 1970 jettisoned the time-based classification under the various international conventions for a more medically sound one. It did not only resolve the Schedules and Tables under the international conventions into Schedules I, II, III, IV and V under Part B of the CSA[xxxiii], but also gave the medical reasons for the placement of substances in each schedule thus:

(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 US

(C) There is lack of accepted safety for use of the drug or other substance under medical supervision.

(2) 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 US 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.

(3) 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 US

(C) Abuse of the drug or other substance may lead to moderate or low physical dependence or high psychological dependence.

(4) 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 drugs or other substances Schedule III.

(5) Schedule V-

(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 US

(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.

Besides listing the substances in each schedule on the basis of pharmacological actions, the minimum quantities requiring legal control are disclosed. This way, the lumping together in one schedule of substances with varied CNS actions does not blur the degree of control appropriate for each. No doubt, the additional information from the mode of classification adopted by the US is of immense jurisprudential value in the teaching of substance abuse and trafficking.

Curiously, the Ghanaian approach to substance abuse and trafficking appears stunted, both in content and collaboration. Its law on the subject, "Narcotic Drugs (Control, Enforcement and Sanctions) Law, 1990, is only concerned with narcotic drugs. Narcotic drugs under S.9 of the Law is assigned a meaning substantially the same as that under the Nigerian DDA. This means that unauthorised dealings in psychotropic substances and the immediate precursors of narcotic drugs and psychotropic substances are not prohibited in Ghana. This is even more worrisome having regard to the fact that Ghana was represented at the United Nations Conference for the Adoption of a Protocol on Psychotropic Substances held in Vienna from 11th January to 21st February 1971.

Furthermore, the term "narcotic drug offence" is to the effect that only unauthorised dealings in substances specified in the Schedules to the Law amount to prohibited activity[xxxiv]. Substances specified in Schedules I and II to the Law are essentially opium, cannabis and cocaine in their natural or synthetic form. It is submitted, therefore, that the range of substances listed for control by the Ghanaian Law does not reflect modern realities in the global war against substance abuse and trafficking.

Consequently, the creation of Schedules I and II without recourse to substance classification and schedules to the various international conventions is a cause for worry. It is submitted, that the provisions of SS.42, 52 and 53 on mutual legal assistance notwithstanding, the Ghanaian approach is devoid of international legal co-operation necessary to stem the scourge of substance abuse and trafficking. Since the framework for the regulation of substance abuse and trafficking is laid down by the international conventions, Ghana ought to have made provision for their application in the absence of any reservations to substance classification. This was necessary even if most of the substances were not abused in Ghana at the time of enactment. Moreover, mutual assistance in the drug war on the international plane is based on the substantiality of equivalent provisions in the domestic Laws of the Parties.

One other common classification of drugs liable to abuse and trafficking is into hard and soft drugs[xxxv]. According to Albrecht[xxxvi], the consumption of illicit drugs in all European countries is dominated by the so-called soft drugs (cannabis and its derivatives). In the same vein, Asada[xxxvii] maintains that soft drugs comprise of Khat, Kratom and other hemp products like marijuana and hashish.

Textually, hard drug[xxxviii] is defined as a drug that has very strong; often dangerous effects and can cause people to be addicted and soft drug[xxxix], as an illegal drug considered unlikely to cause addiction or to be very harmful. With the examples of soft drugs mentioned above and empirical happenings in the drug world, the consideration for this mode of classification becomes vague and meaningless. For a certainty, Indian hemp is both addictive and pernicious.

This nebulous classification was presumably responsible for the dilemma faced by the British Government over its decision in January, 2004 to downgrade cannabis from Class B to Class C drug. Barely one year after the decision, the Home Secretary, Charles Clark, was forced to call for a rethink because of the growing evidence of a link between cannabis abuse and mental health problems. The Daily Sun[xl] captures the melodrama thus:

'Skunk' cannabis emerged from the hippy communes of California in the 1970s and has become the mainstay of the drugs trade in Britain in the 21st century. It was developed in illicit laboratories by cross-fertilising different varieties of the plant to produce the strongest cannabis possible. It is grown across the country in 'skunk farms' by organised drugs gangs. Skunk is said to be up to ten times stronger than conventional cannabis and medical research has revealed that it can trigger serious psychotic episodes, including hallucinations and paranoid delusions.

This episode re-enforces the assertion that Indian hemp is both addictive and pernicious.

A further development in Britain, in 2005, as reported by The Daily Sun[xli] has shed more light on the illicit production and use of Indian hemp. Quoting a confidential Scotland Yard dossier as its source the Newspaper reports:

Hundreds of 'cannabis factories' have been set up following the government's controversial decision to relax the laws on the drug. In London alone, there are thought to be at least 300 such sites operating at any one time – producing drugs with a street value of up to150 million (pounds) a year…The plants are grown in pots filled with soil, which produce high yield, or in hydroponic water tanks, which speed up growth.

The Daily Sun concluded its report by saying that cannabis was reclassified from a Class B to a Class C drug in January 2004 and that most users caught by Police are now given a formal warning but do not receive a criminal conviction.

No doubt, this correlation between production, use and psychotic episodes puts Britain on the verge of social upheaval. Already the confidential Scotland Yard dossier has the report of an increase in the number of shootings as rival drug gangs fight over territory. When eventually users graduate from non-violent street crimes to violent and organised crimes then the situation is better imagined.

Curiously, the World Drug Report (WDR) appears to have classified cannabis as a soft drug in its treatment of main problem drugs thus:

The definition of a problem drug relates to the extent to which use of a certain drug leads to treatment demand, emergency room visits (often due to overdose), drug related morbidity (including HIV/AIDS, hepatitis etc.), mortality and other drug-related social ills, such as drug related crimes and violence. The term problem drug does not relate to the size of the population consuming it. Cannabis, for example, is the most widely consumed illegal substance worldwide; it is not, however, the main problem drug in terms of the adverse health and social consequences described above[xlii].

This work agrees that cannabis is the most widely consumed illegal substance worldwide but submits that in Nigeria, cannabis is also the main problem drug in terms of the adverse health and social consequences described above. For example, when the writer visited the Psychiatric Unit of the Dalhatu Araf Specialist Hospital, Lafia, in November, 2005, he discovered that of the thirty (30) cases of psychosis reported in 2003, medical diagnosis revealed that ten (10) were caused by the use of Indian hemp.

The above exposition underscores the irrelevance of the hard/soft drugs classification to the Nigerian situation and, *a fortiori,* it's utility in the drug war. Indian hemp should, therefore, be classified as a hard drug and subjected to control measures applicable to hard drugs. Commendably this is the position under the NDLEA Act. Also, to be noted is the submission of Appelbe et al[xliii] on the classification of addiction-forming drugs into Class A, B or C by the English Law to the effect that the severity of penalties is determined by the degree of harmfulness of the drugs. This work finds Appelbe's submission unsatisfactory because a drug may be harmful but yet useful, in which case, the risk/benefit ratio becomes the decisive factor. In other words, a drug may be harmful, even toxic but approved for medical use especially where there is no alternative therapy. This is the case with cytotoxic drugs for the treatment of cancer and anti- retroviral drugs for HIV/AIDS. Expediency, rather than the degree of harmfulness become the factor for determining the level of regulation for such drugs. But where a drug is shown to be harmful, however slight and not approved for any medical use, the appropriate action to take is to completely discourage its use by imposing stringent penalties. It is, therefore, submitted that the listing of cannabis as a soft drug under the hard/soft drugs dichotomy is misleading and any drug control policy drawing inspiration therefore is bound to fail.

Obviously, the Nigerian mode of classification of substances liable to abuse and trafficking is unsatisfactory for being time-based, and for ignoring the pharmacological actions and the quantity of individual substances in question. The Ghanaian approach is retrograde and should be disregarded. So far, the US mode of classification is most appropriate and should be adopted by Nigeria.

4. Conclusions

This work examined the indiscriminate use of terminologies and inadequate classification of drugs liable to abuse and trafficking. In so doing, the various epithets in use, both in texts and oral discourses in relation to this category of drugs were analysed and the correlation with inadequate classification brought to the fore. In conclusion, therefore, this work holds the view that:

a. most of the epithets attached to this category of drugs have fallen into oblivion for being redundant, too restrictive and inelastic and so there is the continuing need for search for enduring definition, especially with the growing sophistication of drug abuse and trafficking.
b. any definition that ignores the habit-forming propensity of this category of drugs is unhelpful and destitute of any practical value.
c. having regard to the classification into the various schedules of the relevant international convections for drug control, it is better to re-enact the conventions as did the US and Ghana than the adoption by Nigeria to allow for inter schedules transfer.
d. because the absence of proof through laboratory analysis that the suspected substance is one prohibited by the law no accused can be convicted, the abuse of strange substances in Nigeria requires medical characterization of the substances through legislative measures to put the trial of drug offences on a sound footing.

5. References

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iii. http://www.businessdictionary.com/definition/drug-abuse.html, Accessed 2/6/2017 at 11:00 am.
iv. It is a behavioural pattern of drug use, characterised by overwhelming involvement with the use of a drug (compulsive use), the securing of its supply and a high tendency to relapse after withdrawal.
v. It is a state, psychic and sometimes physical, resulting from the interaction between a living organism and a drug characterised by behavioural and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects and sometimes to avoid the discomfort of its absence. Drug dependence is either psychological or physical. Psychological dependence is an attachment to a drug/substance to satisfy some emotional or personality needs of the user. Physical dependence is a physiological adaptation, which demands continuous supply of the drug in order to prevent serious and sometimes fatal physical withdrawal symptoms.
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viii. S.10 of the Dangerous Drug Act, CAP D1, LFN, 2004.

ix. Ibid, S.8 (3)
x. Ibid, Loc. Cit.
xi. Goodman and Gilmann's, Op. Cit., P. 545.
xii. Oxford Advance Learner Dictionary, Op. cit, p. 772
xiii. S. 52 of the National Drug Law Enforcement Agency (NDLEA) Act, CAP N30, LFN, 2004.
xiv. Items 22 and 25 in the First Schedule to the Single Convention on Narcotics Drugs, 1961 (1961 Convention).
xv. S. 802 of the Controlled Substances Act (CSA), 2001 (US).
xvi. Roper, N. Ed.., Churchill Livingstone Pocket Medical Dictionary, 14th ed. (London: Longman Singapore Publishers Pte Ltd, 1987) p.222.
xvii. Good man and Gilmann's, Op. Cit., P.391
xviii. S. 52 of the NDLEA Act.
xix. S. 802
xx. (CAP 152), F & L, 1958, Part III thereof deals with the sale, custody and supply of poisons and drugs. Part v deals with the control of sale of patent and proprietary medicines.
xxi. Article 38 (bis)
xxii. Long Title.
xxiii. Sally Weheier, Ed., Oxford Advanced Learner's Dictionary, Op. Cit., p. 542
xxiv. S. 812
xxv. S. 20 (1), (a), (b) and (f) of Note 14
xxvi. S. 52 of the NDLEA Act.
xxvii. Ibid
xxviii. Second Schedule to the NDLEA Act.
xxix. S. 811 (c)
xxx. Art. 3 of the 1961 Convention, Art. 2 of the 1971 Convention
xxxi. S. 9 (2) of the Ghana Narcotic Drugs (Control, Enforcement and Sanction) (NDL) Law, 1990 (Ghana).
xxxii. S. 811 (a)
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xxxiv. S. 62 of the NDL (Ghana)
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xxxix. Ibid, P. 1129
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xlii. United Nations Office for Drug Control and Crime Prevention, World Drug Report (Oxford New York: Oxford University Press, 2000) pp. 56 & 57
xliii. Appelbe et al, Dale and Appelbe's Pharmacy Law and Ethics 7th Ed. (London: Pharmaceutical Press, 2001) P. 159