FN: Opium, Ch2

August, 2003

CHAPTER TWO

THE OPIUM TRADE AND OPIUM POLICIES IN INDIA, CHINA, BRITAIN, AND THE UNITED STATES: HISTORICAL COMPARISONS AND THEORETICAL INTERPRETATIONS

Richard Harvey Brown

This chapter explores relations between political economy and public policy concerning opiates. In this opening section we sketch two general models of the broad political economic context for drug policy formation in modern societies. We take "policy" to mean official governmental expressions of public goals and norms, as stated especially in laws and their enforcement. By "drug" we mean any substance ingested for the purpose of altering the user's normal state. This includes bioactive and psychoactive substances, whether naturally grown or chemically manufactured. By our definition certain substances may be taken as foods or medicines in one context (to restore the user to a normal state), and as drugs in another context (in which the intention is to induce a change from a normal condition).

In the extensive literature on how public policies are formed there are two general theoretical models: rational order and political conflict. In the *order model*, public policies are seen as emerging from a scientific or utilitarian calculation of the effectiveness of alternative approaches to achieve agreed upon ends. The aim in this view is to solve a problem and achieve the public good. This perspective is taught in high school civics courses and is generally the professional ideology of experts engaged in solving social problems. In the order model, researchers are seen as gathering and analyzing facts and then, on the basis of these findings, developing rational policies to deal with drugs or other issues of public concern.

By contrast, in the *conflict model* research reports are viewed as covers or instruments for what are essentially political decisions. But what exactly are the political forces that might shape the questions and conclusions of advisory commissions or social science researchers? Within the conflict model there are two broad responses to this question -- pluralist and elitist. From the pluralist perspective, there are numerous groups in society, each struggling to enhance its own

position, each seeking to use "science" as a rhetoric to legitimate its own interests. Thus whites rival minorities, Catholics rival Protestants, southerners rival northerners, and so on, each trying to shape public policies to their particular advantage, and each using knowledge or reasoning in a partial, self-interested, and propagandistic way.

A second view within the conflict model -- the elitist perspective -- holds that relatively small groups control most strategic resources and institutions. In this view, elites use science as a rhetoric with which to advance their own interests just as non-elite groups try to do. But, in addition, elites also use the imagery of pluralistic conflict itself—the image of various groups fighting it out in the domestic arena—to cover the fact that most issues are "wired" in advance by elites.

Thus, the conflict model would hold that drug policies have reflected conflicts between various status groups, but that ruling class factions at times have stimulated pluralistic conflicts or exploited them to their own political and economic advantage. The pluralistic perspective seems to explain conflicts in areas where no elite interest is at stake -- for example, problems of only local concern, or technical alternatives within a broad policy approach that has already been set. But where elite interests are at stake they generally prevail.

However, in no country is the dominant class either monolithic or omnipotent, let alone omniscient. As in the United States, for example, it has internal conflicts, usually based on industrial groupings (e.g., aluminum and petroleum versus iron and coal); dynastic rivalries (the Rockefellers and Mellons against the du Ponts and Morgans); regional differences (the Sun Belt versus the Eastern Establishment); and national versus international interests (the National Association of Manufacturers versus the Committee on Economic Development). Normally the

common interests of elites as a class will supervene over particular interests of segments of that class. In instances where this does not occur, elite factions will seek alliances with elements of the general populace, and pluralistic groups at such moments as may shape policies of national importance. Moreover, cultural, organizational, and other factors also play a role. In the international arena, elite interests usually prevail, especially in colonial or imperialist settings.

In this essay we will explore the adequacy of these three perspectives -- order, pluralist, and elitist -- and try to refine them with historical evidence of use, trade, and policies related to opiates in India, Imperial China, England, and in the United States until the passage of the Harrison Act in 1914. Our historical data suggest that the rational order model fails to account for the cases discussed, and that the conflict model, using both pluralist and elitist perspectives, provides a better framework for the explanations of these events. The most successful interest groups have been able to define the very terms of debate and establish a language of public policy options tailored to their own political economic goals. For elites, this has meant exercising their already considerable political power, while for pluralist groups it has come through a more tenuous combination of grassroots mobilization and access to individuals in positions of power.

Opium in India

Opium may have always been available in India and perhaps was the soma referred to in the ancient Vedas, although some scholars date its introduction to India by Arab traders in the ninth century (Shukla 1970). The habitual use of opium as a stimulant, sedative, and euphoric was probably prevalent in India before any other major society. It was used as a household remedy, to give courage to soldiers, as an aphrodisiac, and as an indulgence of rulers (Owen 1934:3). Early Western observers, such as Duarte Barbarosa or Don Alfonso de Albuquerque

noted its common use (Dane 1895). In 1563, Garcia d'Orta, a physician who sailed to India in 1554, observed that "Although they take it in small quantity, it is a merchandise in great demand everywhere" (Guerra 1974:272-273). In Rajputana the customary greeting to visitors was "Take your opiate." The sharing of opium also was a way of making a contract binding. Even the seals with which contracts and other legal documents were stamped bore the inscription "Take a draught of opium" (Fields and Tarrarin 1970:373). Although the drug was taken in small doses, habituation did occasionally result.

The use of opium in India was embedded in social and religious customs that were often particular to certain jaati or caste groups. For example, in addition to sealing an agreement, indulgence in opium often was socially expected on occasions such as marriage or death. Also, some religious sects took various drugs including opiates to assist in freeing the mind from worldly attractions (Chopra and Chopra 1957:21-2). To meet this demand, opium was extensively cultivated in India for at least a millennium and opium use was generally not regarded as a significant social problem even during British rule.

A documentary record of opium use begins during Muslim rule in northern India from about the thirteenth century, when opium use was noted in traditional aurevedic and folk medicine and in organized ceremonies and celebrations. Licit distribution was limited to forms suitable for eating rather than smoking (Blum 1969:47-48). There were sporadic prohibitions, however, such as the total ban imposed on the city of Delhi by Allauddin Khilji in 1310 (Shulka 1970:301).

During the first Moghul dynasty, begun in 1524, poppy cultivation and the sale of opium became state monopolies and opium became an important article of trade with China and other

countries of East Asia (Kohli 1966:3). During the reign of the Moghul emperor Akbar (1556-1605), poppy production was a regular source of revenue to the state (Owen 1934:5).

The Moghul Empire in India collapsed following the reign of Aurangzeb (1658-1707). While hegemony was being contested by expansionist Marathas, by French and British imperialists, and by Aurangzeb's own heirs, control of the opium trade was appropriated by merchants in Patna (Kohli 1966:3). The British soon established dominion, however, and in 1757, the opium monopoly passed into the hands of the British East India Company by edict of the first British Governor General of India, General Warren Hastings. From then on British companies became the principal shippers for foreign trade, of which opium was a major component (Kohli 1966:302; Syukla 1970:3). The British established controls over cultivation and production and tried to popularize the use of opium to increase revenue. At the same time, however, Hastings declared that opium was a pernicious article of luxury that should be restricted and "which the Government should carefully restrain from internal consumption." Later he encouraged the control of opium by the East India Company, hoping that by monopolizing the supply he would discourage its consumption while maximizing revenues from the limited monopoly, which lasted throughout his administration and beyond.

In 1813 the British government in India reinforced this policy with the Bengal Resolution, which sought to restrict the habit of opium eating while obtaining the "maximum revenue from the minimum consumption." The Government wished to limit a habit that it found impossible to eradicate, even as it monopolized the commodity and sought to profit from it (Chopra and Chopra 1955:1). The British trade in opium increased after 1820 to an annual average 10,114 chests, half of which was Malwa opium. Because this type was not controlled by the East India

Company it presented a challenge that the company met by expanding production of Bengal opium to force down prices. Soon the East India Company had full control of Bengal opium and also increased dominance over Malwa opium.

In 1858 the "Act for the Better Government of India" transferred sovereignty from the East India Company directly to the Crown. The opium system, which remained the same, was now the largest source of revenue for the Indian treasury after land and salt, estimated to have been producing over one seventh of the total income (Archibald 1970:244-245). A period of "mad expansion" of cultivation began with the government always aiming to regulate and adjust provisions so that the largest possible net revenue would be gained.

The cultivation of opium served British authorities by financing the colonial administration in Bengal. For British merchant companies chartered by the Crown, opium was part of a triangular trade: the commodity was grown in India, shipped to China where it was exchanged in Canton and Shanghai for silver, tea, and silk, which were then shipped and sold on the London markets. Opium also began to be exported to Britain and America where it was used as a medicinal in the form of laudanum. Policies regarding opium in India were determined by Britain's overall trade and imperial interests until the twentieth century. After 1900 however, several nations sought to reduce the international trade in opium, and this also effected opium policy in British, and later independent, India. The period of 1920-40 showed the greatest decline of use to date in India. One example of anti-opium actions were those taken by the Indian National Congress Party, which by then had come to power in some provinces. The Congress Party began to prohibit opium use locally in 1937, and plans were made to introduce total prohibition gradually throughout all of India. When the Congress came to power in Assam

in 1938 it put into practice the recommendations of the Assam Provincial Committee; the State government stopped the sale and consumption of opium completely in the three districts of greatest use even though this meant considerable loss of revenue.

Congressional ministries resigned during World War II and efforts at prohibition were discontinued. After the war, taking note of international pressure, in 1946 the British Government in India prohibited the smoking of opium. In 1947, after Independence, the National Congress revived its earlier policy. Now opium production was prohibited except for medical and scientific use. Control of the cultivation and manufacture of opium throughout all of India passed into the hands of the government, which set up a Narcotics Commission as a central organization to unify and rationalize the system of production, pricing, and control.

Between 1948 and 1954, a reduction of 45% in consumption occurred primarily because of the decrease in production and the increase of price. India's policy regarding cultivation of poppy was guided by her international obligations to restrict production of opium to the quantity actually required for export for medicinal purposes, as well as for consumption within India (Kohli 1966:3-4). In 1959 the sale of opium was totally prohibited. Oral consumption was prohibited except for small amounts consumed by registered addicts on medical grounds. The Narcotics Commissioner in India was in charge of controlling cultivation from the time the seed was sown until the opium was collected and sent to factories. Illicit drug traffic was negligible and almost wholly within the domestic market. Indeed, India managed to implement one of the world's most successful campaigns to limit the drug's cultivation and use, a policy that includes state monopoly supervision of the legal trade and medicalization, but not criminalization, of use.

Despite the pervasiveness of opium in Indian history, its use never became as extensive as in China, nor did it engender such extreme concern. It appears that India had less of a problem because opium use there was embedded in a long standing cultural system of norms and sanctions that encouraged moderate use, principally for medical and quasi-medical purposes or in specified ritual and social settings. Further, in India the reaction to opium was affected neither by distrust of foreign imported substances nor by the loss of domestic revenue to outside suppliers (as with opium imports to China). It also may be significant that in India opium use never came to be associated with a particular group nor was anti-opium policy used to stigmatize and regulate that group, as was the case with the anti-Chinese opium policies of the United States. The lack of an egalitarian ideology in so diverse a nation as India may have permitted ethnic and caste rivalries to be contained by traditional hierarchies or expressed more openly and directly, rather than through drug policies that are "irrationally" coded to discriminate against a particular group. Finally, the substance was under the monopoly control of the central government—first the Moguls, then the Raj, and later the national state—and this probably protected opium policy from influence by private purveyors.

The British Opium Trade from India to China

Opium was probably known in China as early as the 8th century, when Arab traders came to the Middle Kingdom (Edkins 1894:29). Mention of its medicinal properties dates back to 973, but it was not until the 1500's that the medicinal use of opium was fully elaborated. Further, although the recreational use of opium may have occurred sporadically since the late 13th century (Kraner 1977), it was not an important issue until the introduction of opium smoking in the early

seventeen hundreds. Around 1700, use of tobacco-opium mixtures (madak) spread from India to Java, the East Indies, Taiwan, and China, especially Fujian and the South China coast. Once opium smoking began, Chinese use was personal or social, that is, unregulated, informal, and neither traditional, ritual, nor medicinal (Blum 1969:50-51). In 1729, the first edict prohibiting opium selling for smoking appeared. From then on, selling opium for smoking was regarded as a crime by the Chinese authorities.

The illegal introduction of opium into China by Great Britain followed a well-established indigenous pattern of illicit commercial enterprise in southern China. By 1500 the economic and demographic development of China could only be sustained by vigorous overseas expansion. As this was forbidden by the inward looking Ming Emperors, the commercial and sea-faring energies of southern coastal Chinese were spent in running contraband and battling with government troops. As Elvin (1973:222-223) noted, "The only class with the power to defy the government ban on coastal and overseas trade was the local gentry. From their role as the protectors and organizers of the massive smuggling that arose in the later fifteenth and early sixteenth century they derived so much wealth that they came to have something of a vested interest in the maritime interdict—so long as it was not too rigorously enforced. A few of them, such as Lin Hsi-yuan, author of The Opening of the Seas, did plead for a relaxation; but most gentry undoubtedly felt that the legalization of sea-borne commerce would have removed the need of the merchants for their well-rewarded protective services". Thus Wang Shi-chen could observe in the middle of the sixteenth century:

> The criminal merchants and sly people of Fukien and Chekiang,
> seeing the fat profits to be made, secretly trade with foreigners in

> prohibited goods. They all of them entrust themselves to the protection of the gentry and the authorities do not dare to enquire into what is going on. (quoted in Elvin 1973:223, note 39).

Thus the British opium trade built on a tradition of southern independence from Bei'ching and a well-developed and often illicit system of Chinese trading.

After the British East India Company assumed control of the opium growing districts of eastern India, Bengal and Bihar, British shipping dominated the trade in Bengal opium out of Calcutta. Opium from Bengal continued to enter China despite the Chinese edict of 1729 prohibiting smoking. Indeed, Chinese consumption of opium from British India increased fivefold in less than forty years, from 200 chests annually in 1729 to 1,000 by 1767, although much of this was for medicinal use. Despite its illegality, tariffs Chinese officials collected tariffs on the opium.

British traders established an opium depot at Macao in 1780 (Holt 1964:219). Chinese imperial edicts again forbade consumption of opium and reiterated earlier prohibition of its sale. Company representatives in Canton argued that the Chinese were insincere in their declared intentions of suppressing illicit traffic since officials who issued prohibitory edicts with one hand extended the other to receive bribes from illegal traders. Reminiscent of exporters of illegal drugs everywhere, the British also insisted that—as China was not able to stop the use of opium—if Britain did not supply it someone else would. Opium had become illicit in China, whereas it simultaneously was a legal British monopoly in India (Owen 1969:76, Dane 1895: Appendix C).

Alarmed by increasing use, in 1796 the Emperor issued another edict forbidding importation of opium, as well as the export of Chinese silver that was being used as a medium of exchange. A strong edict by authorities at Canton supported the Emperor's decree of 1796 and forbade the opium trade at the port of Canton. Because of the outflow of silver, even legitimate trade in commodities other than opium turned more and more to barter. Nonetheless, illegal purchase of opium with silver continued. A further Chinese Imperial edict about 1800 prohibited domestic cultivation and repeated the prohibition against importing opium. Edicts continued to be issued reiterating prohibitions against importation, sale, and consumption. These edicts had little practical effect, however, and opium trading soon resumed at the port of Canton (Chang 1964:219, Owen 1969:64-65).

The Chinese merchant class had grown wealthy from this trade and profited even more as popular demand for opium expanded. Chinese merchants bought tea and silk inland at low local prices and bartered them with the foreigners on the coast for the drug, whose real cash value depended on the merchants' ability to resell it to consumers at much higher prices. The profitability of the opium trade to these Chinese was an essential element in the expansion of the British trade. In this case as in others, supply preceded demand.

As the spread of opium from port cities into the provinces of China came to the attention of the Emperor he issued further edicts mandating harsher measures against violators of the prohibition. The Emperor noticed that opium use had even penetrated the court. He also was incensed that the British traffic violated the traditional Chinese standard of tribute relations with barbarians. In 1830 the Tao-Kuang Emperor for the first time mentioned money wasted on consumption of opium together with its injurious moral and health effects. But it was mainly the

threat to sovereignty and the economic crisis due to the loss of silver specie that precipitated vigorous Chinese action against the import and spread of the drug (Chang 1964:95). In the first important anti-opium trade offensive, the Chinese government imposed harsh new punishments on smuggling and issued new trade regulations that required inspections of ships and a system of bonding.

None of these efforts were successful. Although the Chinese authorities had banned the trade in Canton and discouraged it at Macao, the British did not retreat far. Between 1830 and 1839, 30,000 to 40,000 chests were imported annually. As the market around Canton became saturated with the drug, opium clippers soon spanned the entire Chinese coast. Led by the English trading company, Jardine Matheson, traders sought and found new markets and grew adept at avoiding official obstructions, bribing Chinese officials, and avoiding bonds.

As the Chinese opium trade expanded, it became divided along clear lines of occupation, wealth, and class. Most Chinese consumers, especially the most regular users, were poor rural peasants or urban wage laborers in cities like Canton and Shanghai. Manchu rule in China was already in decline by the 1830's and this was exacerbated by the economic, symbolic and social effects of the opium traffic. The drain on silver specie, China's main official currency, seriously handicapped Chinese commerce and finance. The legitimacy of the state also was undermined by its evident inability to discipline the barbarians. The illegal opium trade also demoralized people, sapped the energy of the army, and corrupted local government and police (Owen 1969:167-168; Chang 1964:15).

Authorities in Bei'ching grew increasingly alarmed. A great debate ensued on how to handle the problem. Senior officials in Canton recommended to the Emperor that the prohibition

against opium be dropped and trade legalized. In this, it was recognized that the imperial policy of criminalization had led to inflated monopoly pricing. One Chinese official declared the "loss of wealth and waste of treasure were exceedingly great...if at this time [opium] were suffered to be brought in and publicly used...as medicine, this would prevent the foreigners from raising the price" (Dane 1895:115). However, the party that advocated a firm prohibitionist policy prevailed, and restrictions on foreigners that already were stringent became even more severe.

On the British side, in 1832 Parliament voted against the renewal of the East India Company's charter for exclusive control of Chinese trade, due to dissatisfaction with the rate of market growth. Lord Napier, Chief Superintendent of Trade of British Subjects in China, was dispatched to the Far East with instructions not to give offense but to persuade the Chinese government to legalize opium and open ports other than Canton to foreign trade. From now on, representatives of the Crown, not the East India Company, controlled the opium trade.

Napier's mission failed to open China for legal British trade. Instead, the Emperor decided to attack opium both at the ports and along its path to consumers. In 1839 he promulgated the 39-Article Statute. Stricter than all previous opium laws, it stipulated execution for both smokers and dealers, including foreign importers and traders. These laws had little or no affect on levels of opium consumption and importation. For example, Lin Tse-hsu, the Commissioner at Canton, found it hard to get informers who actually knew the traffic, in which case they would work for smugglers who could afford to pay much more—an instance of downward co-optation of officials not untypical in drug law enforcement.

With the Chinese and British at loggerheads over what each perceived to be a vital principle and interest, the first Opium War (1839-1842) was fought. The defeat of the Chinese

annulled their efforts to prohibit importation. The British wanted not only to support the drug traffic but also to maintain and expand general trade with China. They obtained their objectives. In the Treaty of Nanking, Hong Kong was ceded to Britain; the ports of Canton, Amoy, Foochow, Ningpo and Shanghai were opened to British trade; restrictions on Chinese tariff policies were instituted; Chinese monopolies were abolished; and an indemnity of 21 million dollars was to be paid by the Chinese. China was now "open" to the West.

Despite British efforts to sell opium and other goods, however, "China's exports increasingly exceed imports. In 1853 British purchases in China were three times larger than sales. Opium was a solution for Britain's mercantilist problem of imbalance of trade, as opium made it unnecessary for Western firms to bring silver to China for purchase of Chinese exports" (Chesneaux et al. 1976:72). In the ten years following the treaty of 1842, the traffic of opium to China doubled.

In 1850, Tao Kuang, the emperor who had tried and failed to end opium smoking, died and was succeeded by Hsieu-feng, who also opposed the authority of foreigners over Chinese life and the weakness of official resistance. Thus relations between China and the West gradually worsened, and came to violence in the Second Opium War (1856-1857). Along with the French who joined in the war, the British extended their powers to distribute opium in China and forced China to adopt Western patterns of commerce. Even the Chinese acknowledged the de facto legality of opium by collecting taxes on it to pay for the war. The Convention of Peking, signed in 1860, finally legalized opium in China. Opium now became another item of legal commerce, subject to taxation and market competition within China. Indeed, following the Chinese defeat in

the Second Opium War and the legalization of opium, taxes on opium helped support the failing Chinese government.

In sum, during the nineteenth century, the British East India Company, under a Royal Charter, conducted a triangular trade between England, India and China. India was the source of fibers and China the source of spices, precious metals, and fine finished goods. English mills turned Indian raw materials into cloth, establishing a colonial reciprocity between those two countries. But the Chinese Emperor did not wish to trade with westerners, and the westerners were buying vastly more than they were selling in China. In response to this situation, and in opposition to the pleas and decrees of the Emperor, the British illegally sold Indian opium for profit and in hopes of balancing their trade deficit. When the Emperor's fleet attempted to intervene against the British traders, it was interdicted by the British navy, as in the Opium Wars of 1839-1842 and 1856-1857.

Thus the history of opium use in China is a story of the impotence of state edicts when opposed to powerful economic interests backed by military force. For 130 years, beginning in 1729, the opium trade into China was illegal, yet it expanded continuously. By 1859 it had been legalized. At one point, India's exports of opium to China provided an estimated 14 percent of the official revenue of British India. The accomplishments of contemporary organized illegal drug traders seem to be relatively modest when compared with those of the British East India Company and later the British Crown, which for more than a century bribed, bullied, and waged war to promote their product in a huge country that had officially excluded it (Archibald 1970:244).

Only in the early 20th century did things begin to change. China itself was beginning to modernize politically and economically, and becoming more able to resist foreign incursions. In addition, with of the U.S. acquisition of Hawaii and, after the Spanish American War, the Philippines, the United States had become a Pacific power unsympathetic to British hegemony in the region, including its quasi-monopoly opium trade. At the same time, the Western pharmaceutical industry had developed to a point of internationalizing its trade, and opium was a competing substance now defended only by the British. Finally, there developed a moral revulsion to the trade among the British public itself. Thus in the early nineteen hundreds China was able to start a program of tapering off the massive dependence of its population on opium. Uncontrolled opium use was finally eliminated with broad popular support after the victory of the Chinese Communist Party in 1949. With greater economic and social freedom since 1979, however, the use of opiates has reappeared in some southeastern cities.

The contemporary Colombian expression, plata o plomo (bribes or bullets) had its forerunner in the policies of the British Crown. But rather than the covert, organized crime-style military efforts of international drug traders today, the British government itself was quite openly responsible for forcing opium on China—and they had no qualms about going to war to protect that very lucrative trade. There also is a parallel between British India and China regarding opium, and Colombia and the United States regarding cocaine. In both cases the importing nations, respectively China and the United States, developed greater drug problems than the producers, India or Colombia. China as compared to India lacked moderating social controls for opium use among the lower classes and, hence, recreational or retreatist opium smoking was

more prominent. Similarly, in Colombia as in other Andean republics, coca is an indigenous drug with traditional social controls of its use.

Still, the difference of the quantities and social meanings of opium use in India and China remain problematic. The official and later popular Chinese antagonism towards opium was rooted in hostility toward the foreigners who imported it. The trade in India also was dominated by foreigners, the British, but they had become the Government of almost all of India by the mid-nineteenth century. Moreover, the British government in India supported the production and sale of opium and greatly profited from it, as had the Mogul rulers before them (Blum 1969:47-48). Opium was legally advertised and merchandised in India within the limits of Government restrictions on kinds of preparations permitted and kinds of settings tolerated for use. In India the trade was profitable for ruling elites, who imposed a policy of temperance but not prohibition. By contrast, in China the traffic undermined the Emperor politically, ideologically, and financially, and the policy was one of prohibition under penalty of death. These differences of elite interest and public policy between the two countries may partly explain why opium use was thought to be a major social problem in China, whereas in India it received little public attention. The "opium problem" was discussed at successive international commissions beginning only in 1903. Their aim was to suppress international (and eventually domestic) trade of traditional drugs such as opium in favor of the new pharmaceutical drugs being marketed by Europe's and America's rising chemical industries.

Opium in the United Kingdom

The use of opiates in Britain contrasts with that in India and China. During the nineteenth century opiates were probably more extensively employed in England than in any other European country. They were taken with or without medical authorization for major, minor, or even imaginary ailments, and sometimes exclusively for their euphoric effects (Lomax 1973:167). Every medical authority agreed that the drug habit was spreading. Still, the level of opium use did not approach that of alcohol consumption and did not yet arouse great public concern.

In the mid-nineteenth century the British saw opium as a legitimate product for international commerce, akin to the lucrative trade in alcohol, tea, or coffee or, for that matter, textiles and other manufactured goods. Britain imported 40 tons of opium in 1860 compared to 10 tons in 1830. Opium was variously on and off the official list of poisons in England because there was no agreement on what should be done with such a popular, versatile, and potent drug (Lomax 1973:176). The first control of opium in England occurred when public concern was aroused by the use of poisons, often opiates, in a series of murders. The national press clamored for government intervention, and in 1857, a bill was proposed to restrict and regulate the sale of poisons including opiates; but because of vigorous opposition by members of the Pharmaceutical Society the bill was not enacted until 1868 (Spear 1975:172).

The Pharmacy Act of 1868 stated that opiates could only be sold by a registered chemist or druggist, or by a legally qualified apothecary. However, there was no restriction on the amount sold, and patent medicines (often heavily laced with opium) were specifically excluded from the regulations. Moreover, although the government knew that infants were sometimes drugged and killed by opiates, it did not act decisively on their behalf (Lomax 1973:176).

Various religious groups and moral reformers, disturbed over the British exploitation of the Chinese, began a crusade against the opium trade. In 1874 the Society for the Suppression of the Opium Trade was organized and heavily financed by Quakers. The Society gained support from all segments of British Christianity (Johnson 1975:2). The British Liberal Party also supported the anti-opium crusade, and when it took over Parliament in the mid-1890's it appointed a Commission to determine whether the opium trade should be ended or not. The Commission held hearings in London and India at which most witnesses were pro-opium, and its report totally vindicated the opium trade (Johnson 1975:313-316, Owen 1934:318-320).

By affirming the system as it stood, the Commission provided a parliamentary rationale for British policies in India and the revenue that these accrued. But Henry Wilson, the belligerent non-conformist of the Commission, vigorously registered his dissent, charging that the report was more "an elaborate defense of the East India Company and of the present Government of India than...a judicial pronouncement on the immediate questions submitted to us." The Commission had in fact allowed itself to be guided by the British Indian authorities, and this prejudiced the acceptance of its conclusions (Owen 1934:320, 324).

The British medical profession also abandoned the China opium trade to the laws of supply and demand, and Chinese opium smokers to the Puritan principle of self-help. This was in part because of a Victorian laissez faire aversion to government intervention, and in part because they believed in their cures for addiction. The profession also withheld support from the Society for the Suppression of the Opium Trade, which took a supply side approach and saw the suppression of Indian opium cultivation as the best way to put an end to opium use in Britain (Miskel 1972:8). In the 1890's, through a series of court cases, the Pharmacy Act of 1868 was

interpreted to include patent medicines. All these preparations, including infant sedatives, from then on had to be labeled Poison and could be sold only by registered chemists. As a result, infant deaths due to opiate poisoning declined and the power and prestige of the medical profession to regulate behavior was enhanced. As in the United States, an important stream of pro-regulatory sentiment in Britain favored honesty in labeling to assist proper use.

At the turn of the century, however, pressure from the now international anti-opium movement and especially from the United States led Britain to abandon its laissez-faire policy toward use at home and production abroad. In 1906, after the election to Parliament of anti-opium supporters, the British government decided to end the opium trade with China. The Pharmacy Act of 1908 placed opium, and all preparations containing one or more percent of morphine, into Part One of the Schedule of Poisons, that is, among the more severely restricted drugs. Because of concern over opium smoking in Britain's own Far Eastern territories, the British also attended the Shanghai Opium Conference of 1909 and later the Hague Opium Convention of 1912. These and subsequent international agreements on drug control helped to shape Britain's evolving drug policy throughout the 20th century.

In 1920 Parliament passed the Dangerous Drug Act, which was similar to the U.S. Pure Food and Drug Act of 1906. Consistent with the various international conventions that Britain had endorsed, such as the Hague Convention of 1912, the Dangerous Drug Act required that the distribution of opiates be restricted to medical channels. The only limitation imposed by the laws on a doctor's right to possess and supply controlled drugs was that the use of the drug be necessary in providing medical care. Significantly, the various international conventions and national laws also established a distinction between medical and nonmedical uses of substances.

In order to determine if the requirements of the Dangerous Drug Act were being followed, the Minister of Health appointed a Departmental Committee on Morphine and Heroin Addiction, known as the Rolleston Committee. Although it was apparent to the Committee that doctors were prescribing narcotics for "nonmedical" as well as "medical" purposes, it saw no reasons to regard non-therapeutic addiction as a serious threat. The Committee recommended that two groups of persons could be legally prescribed narcotics: those who are undergoing treatment for cure by the withdrawal method; and those who, after every effort had been made to cure their addiction, could not be completely withdrawn. The Committee also recommended that tribunals be set up to deal with doctors who contravened the guidelines proposed by the Committee (Spear 1975:70-78).

Contrary to the perspective, prevalent in the United States, that addiction is a criminal or moral issue, addiction came to be seen in Britain as essentially a medical problem. The Committee maintained that "with few exceptions addiction to morphine and heroin should be regarded as a manifestation of a morbid state, and not as a mere form of vicious indulgence" (Shur 1968:70-71). Indeed this statement aptly characterizes the British approach to addiction from 1920 to the present day. The Rolleston Committee also recommended that physicians be allowed to prescribe heroin and morphine to their patients and rejected institutionalized treatment. The Rolleston Act, passed in 1926, gave doctors the right to prescribe narcotics on their own judgment. This law was the primary basis of narcotic drug legislation in Britain until 1967.

Signs of an increasing use of heroin appeared in the 1950's in England, as in the theft from a hospital in Kent of a large quantity of morphine, heroin, and cocaine. When the thief was

apprehended, his customers were revealed to be patients of a number of London doctors. Still, only 301 persons were reported as "addicts" in 1951. However, as synthetic analgesics were becoming broadly available, the Brain Committee was established in the late 1950s to review the recommendations of the Rolleston Committee. The Committee reaffirmed the major findings of the Rolleston Committee and concluded that the incidence of addiction was very small (Spear 1975; Spear and Glatt 1971).

From 1962 on in England, the nonmedical use of heroin by young males was the main source of continued increases throughout the decade. In 1965, the number of known addicts was 927; in 1967, 1,729, of which approximately 1,300 were reported as heroin addicts. By 1968, 30% of these addicts were males under the age of 20. The socioeconomic backgrounds of these addicts did not diverge significantly from those of the general population, and their official number represented considerably less than one thousandth of one percent of the British population. Nonetheless, because of the increase in narcotics use, the Brain Committee was instructed to undertake another inquiry. It had four major recommendations: that ordinary patients should continue to be prescribed by doctors; that a system of notification of addicts should be established; that special treatment centers should be set up; and that the supply of heroin and cocaine should be confined to doctors at the treatment centers (Josephson 1973:180-183; Hawks 1971:55, 1974:141; Johnson 1975:75).

Another Dangerous Drug Act was passed in 1967 following the recommendations of the Brain Committee. It restricted the prescription of heroin and cocaine for addicts to specially licensed doctors on the staff of designated treatment centers, who often substituted methadone for heroin. The Dangerous Drug Act also required doctors to notify the Home Office of persons

whom they suspected of addiction. There was a steady decline in the numbers of addicts so reported. Immediately following the Act, the illicit price of heroin increased as did the illicit trade in "Chinese" heroin, methamphetamines, methaqualones and injectable barbiturates. Also, at this time the police began to vigorously enforce new laws dealing with the possession of and trafficking in various other drugs, and the number of arrests and convictions for drug offenses mounted rapidly (Josephson 1973:176). The Misuse of Drugs Act was passed in 1971. Tribunals were set up to deal with doctors who contravened the laws. If doctors were found to irresponsibly prescribe drugs or to fail to report on addicts, the tribunals had the ultimate sanction to withdraw the doctor's right to prescribe.

In sum, opium was long known and used in England, and became increasingly popular during the 19th century. As in the United States at this time, doctors prescribed opiates liberally as one of the few therapeutic agents then available; patent medicines and opium preparations were readily available without restrictions. Especially prominent was working-class use of opium-bearing nostrums as sedatives for children. "Recreational" use of opium was limited, however, despite some well known cases among 19th century literary personalities such as Byron, Shelly, Coleridge, Dickens, and Thomas DeQuincy, whose Confessions of an English Opium Eater became a sensation when it was published in 1821 (Hayter 1968). There is no evidence that abuse was so excessive as to be a public concern. The attention that did exist was focused more on opium smoking in the Eastern colonies and was in protest over the opium trade itself. A far more serious public health issue, in the views of many contemporaries, was excessive alcohol consumption. Opiate use was not approved, but it was tolerated and not regarded as a social problem.

Starting in the mid-nineteenth century, however, a more negative attitude toward opium began to develop, partly because of a noticeable rise in use in England and partly because of the attention engendered by the Opium Wars with China. Still, it was not until 1906 that the opium trade was ended and not until World War I that a need was felt for special domestic control measures. Even then the primary concern was over an outbreak of cocaine use; opium was included in the controls not because of a perceived problem but in order to prevent smuggling from Great Britain to China. But the climate of both popular and elite opinion was changing in response to the influence of the anti-opium movement domestically and internationally. Opiate use was medically restricted rather than criminally prohibited and removed thereby from general consumption.

Unlike the situations in India or China, where the British government was little accountable for those whom its policies affected, in England the elite's policy of revenue maximization was moderated by a number of other interests. One of these was the medical community and lay citizens concerned about public health. They were satisfied by honest labeling, by the categorization of opiates as toxins, and by limiting the dispersal of opiates to doctors prescriptions in special treatment centers. Another interest group in Britain was the pharmacists and apothecaries who had been able to sell opiates without restriction. Their interests were not met by the new restrictions but, by the same token, they may have been gaining generally by the rise of the chemical pharmaceutical industry that was rapidly replacing natural substances with manufactured drugs. Indeed, the distinction in the Dangerous Drug Act of 1920 between medical and non-medical uses of substances soon became a distinction between traditional natural drugs like opium and modern manufactured pharmaceuticals that were retailed

by the pharmacies. A consensus slowly emerged in which medical use was the only legitimate function of opiates, and even then a preference had emerged for synthetic equivalents. A final major interest that affected British opium policy was international anti-opium pressures, particularly from the United States. These pressures were motivated in turn by an international moral reform movement, by American imperialist ambitions in the Pacific, and by the emerging international pharmaceutical cartel. We will take up these themes below.

Opiates in the United States

The incidence and awareness of opium use in the United States began to increase in the latter half of the 19th century. The American view of opiate use was shaped variously by a number of factors. These included the introduction of opium smoking and a growing anti-Chinese feeling, especially among working class whites in the American West; the image of soldiers wounded during the Civil War being treated with morphine; the widespread use of patent medicines laced with opiates; the introduction of heroin; the growing strength of the temperance movement; the rise of the United States as a Pacific power and world-wide economic competitor of the British; and the rapid expansion of the pharmaceutical industry. We will discuss U.S. opiate policies chronologically and then treat these factors analytically.

The first important legislation in the United States concerning opium was a revenue device passed in 1840 to tax the importation of opium. Then, in the 1850-1860's, tens of thousands of Chinese laborers immigrated to the western United States in a period of labor shortage. Changes began to appear in both the patterns of opium use and attitudes toward this drug, which increasingly was associated with Chinese immigrants, especially when smoked and

not drunk. Opium smoking spread from Chinese to whites, principally those adventurous persons who frequented the Chinese ghettos that had recently been created through racist residential restrictions (Lyman 1977). In these Chinatowns there were very few women and many young men, a demographic situation that encouraged gambling, prostitution, and the recreational use of drugs.

Between 1865-1914, the use of opiates became much more widespread in drinking unregulated patent medicines rather than through opium smoking. Almost all social groups used medicines made with opium and alcohol, though they were especially popular with middle-aged, white, middle-class women who took them for "female troubles." In 1880, one survey of opium "eaters" found females outnumbering males 3 to 1; calling its chronic use a "vice," the report admitted that most would not agree. More typical of public opinion at this time was Dr. J.R. Black, who declared that morphine was less inimical to healthy life than was alcohol. It calms instead of exciting, he said; it is less productive of acts of violence or crime and is less costly and less likely to cause disease (Duster 1970:12). Such tolerance may have been due to the relatively high status of those who drank opium. For example, a Massachusetts survey indicated widespread use, with morphine being sold most frequently to persons with high incomes. Likewise, Dr. William Stewart Halstead (d. 1922), a renowned physician who helped found Johns Hopkins Hospital, used morphine in large doses throughout his highly successful surgical career (Brecher et al. 1972:33-37).

By contrast, opium dens in California were patronized mainly by Chinese, but there is no record of public concern prior to the 1870s. In fact, labor contractors offered an allowance of half a pound of opium per month as a bonus to attract Chinese laborers and perhaps also to keep them

working at a low wage. By the 1870's, however, many Chinese in California had moved from their initial role as "coolie" labor building railroads, draining swamps, or working in mines, and by 1880 they were distributed among a variety of occupations. They dominated manufacturing of boots and shoes, cigars, and bricks, and had become economically important as relatively high-skilled labor in agriculture and fishing. Thus, in times of economic distress small manufacturers and white artisans and laborers were united in blaming their problems on cheap Chinese competition. Exclusion of Chinese became a rallying cry of the working classes, and the use of opium became one of the issues around which the conflict was focused. For the first time, official notice was taken of opium dens, although even now they were not attacked as harmful per se.

Reports of widespread opium use in California appeared in the mid-1870's, when anti-Chinese demonstrations and the campaign to cut off immigration also began in earnest. This period, roughly 1875 to 1880, is the first of the great U.S. anti-narcotic crusades. The first ordinance against opium smoking and opium dens was passed in San Francisco at this time, making it a misdemeanor to "keep, or maintain, or visit, or in any way, contribute to the support of any place, house, or room, where opium is smoked." However, the actual importing and selling of the drug was not defined as a criminal act, nor was ingestion of opium by drinking. As a result, this ordinance never attempted to stop the importation and the use of opium, but merely served to intimidate the operators and clients of opium dens, who usually were Chinese. The ordinance contributed to the general harassment of the Chinese and projected an image of them as criminals (Marks 1975:61-62).

Local and state regulations against opium smoking were passed elsewhere as well. In 1877, Nevada prohibited retail sales of opium for smoking; soon twenty other states enacted

statutes that prohibited either the operation of dens or the smoking and possession of opium. Most of these states are in the West where the Chinese were concentrated. This connection between drug regulation and minority repression was noted by an Oregon appellate court. Writing on the constitutionality of an opium prohibition, the judiciary wrote, "Smoking opium is not our vice, and therefore, it may be that this legislation proceeds more from a desire to vex and annoy the `Heathen Chinese' in this respect, than to protect the people from the evil habit".

One leader of the anti-opium, anti-Chinese hate campaign was Samuel Gompers, president of the American Federation of Labor, who invented a threat of opium-crazed addicts to use against Chinese workers. Gompers, who was known as "the most articulate champion of the anti-Oriental cause in America," described what happens to white boys and girls in the Chinese Laundry rooms: "What other crimes were committed in those dark fetid places when these little innocent victims of the Chinamen's viles were under the influence of the drug, are almost too horrible to imagine...There are hundreds, aye, thousands, of our American girls and boys who have acquired this deathly habit and are doomed, hopeless doomed, beyond the shadow of redemption".

The California legislature passed a state anti-opium law in 1881. Other states soon followed. In 1882, a resolution was presented in San Francisco to legalize opium smoking only in licensed dens (Marks 1975:61-62). In 1883, Congress raised the tariff on opium prepared for smoking. The importation of opium by Chinese, but not by Americans, also was forbidden. On January 12, 1888 the Secretary of the Treasury reported that the effect of opium smoking laws had been to stimulate smuggling by organized gangs, concluding, "Although all possible efforts have been made by the Department to suppress the traffic, it is found practically impossible to do

so". In 1889, San Francisco passed yet another opium ordinance increasing the then $10 fine for a visitor to an opium den to either $250-1000, a county jail term of 3-6 months, or both (Dillon 1962:30). Also, at this time, a license was required in order to sell opium.

The history of opium legislation in San Francisco had other inconsistencies. The initial policy penalized the selling of opium and the keeping of opium dens, but this stand was compromised after it was found that taxing opium could provide revenue for the city. Thus, one observer of the day expressed hope that "Perhaps some lawyer can be found to harmonize these conflicting ordinances and tell us how the city can enforce the 1889 law, and yet license the sale of opium" (Masters, quoted in Marks 1975:61-62). In 1890, the tariff on opium for smoking was increased from $10 to $12 a pound, while the manufacture of such opium was limited to American citizens. Despite the fact that the revenues from these taxes were accepted, there was meager support for a federal law banning opium. In 1904, the New York state legislature passed the Boylan Act, the first comprehensive legislation aimed at controlling derivatives of opium. About the same time a drug journal estimated that 50,000 patent medicines were being sold, almost double the figure for the previous year. The first Pure Food and Drug Act became law in 1906, requiring that all narcotics, including cannabis, be listed on the labels of patent medicines shipped in interstate commerce. Within a few years, the sales of patent medicines containing these drugs dropped by one third. After 1909 the importation of opium prepared for smoking was prohibited at the national level.

Until the late nineteenth century the United States could well have been called a "dope fiend's paradise" (Brecher et al. 1972:31). There were no restrictions on importation other than a tariff; opium and morphine were cheap and readily available without prescription, particularly as

ingredients in countless multi-drug patent medicines that were widely advertised and used by people of all groups and classes as cures for every conceivable ailment. Indeed, opium was so valued in the medical profession that physicians often referred to it (and later to morphine) as G.O.M. -- God's Own Medicine. The introduction of morphine and the hypodermic needle by the late 19th century added to the concerns over opiate use, but it was not considered menacing. By the end of the century, the habituating aspect of opiate use was well understood, but there was little popular support for a ban. From 1860 onwards, opium smoking began a slow but steady rise. However, in 1896 the per capita importation of crude opium gradually began to decline, as consumption dropped in the face of agitation for strict controls (Kramer 1976).

Thus, anti-opium legislation in America had more to do with fears of a competing ethnic group than with concerns about the toxicity of the drug itself (Bonnie and Whitebread 1974:14). Opium smoking was symbolically associated with Chinese immigrants who were actively persecuted. This was especially true in the West during the depression of the late 1880's that exacerbated conflict between white and Chinese labor (Helmer 1955:3). By 1909, when opium smoking was banned, Chinese also were almost totally excluded from immigrating into the United States.

At the international level, the United States Senate passed a resolution that acknowledged the need for national and international action to protect "uncivilized" people from opium and alcohol. One example of this civilizing mission was the United States' actions in the Philippine Islands, which had become an American protectorate after the defeat of Spain in the Spanish-American War of 1898 and the U.S. suppression of the Filipino independence movement. American Protestant missionaries soon arrived to the Philippines to "uplift and civilize and

christianize" the natives, as President McKinley put it (Morrison 1965:805). One of them, Bishop C.H. Brent, imagined an enormous debilitating opiate problem there. Bishop Brent gained the ear of President Theodore Roosevelt, and incited the U.S. and some of its allies to suppress opium use in the Philippines. This ended the previous Spanish policy of permitting the use of opium and taxing it heavily. In 1905 the U.S. Congress passed the Philippine Tariff Revision Act which ordered an immediate opium prohibition for Filipinos, except for medicinal purposes. Within three years the law also became applicable to non-Filipinos, mainly Chinese, in the islands. These policies generated a switch to other drugs and the start of criminal smuggling and distribution (Mandel 1973:23-24).

In 1906 Bishop Brent wrote to President Roosevelt urging an international meeting of U.S. and other great powers with interests in the Far East to help China with its struggle against opium trafficking. Brent argued that only after this was done could the opiate prohibition in the Philippines be effective. Roosevelt strongly supported Brent's proposal, partly because the conference would help his efforts to make the U.S. a stronger force in the Pacific. Moreover, China was in danger of being carved up by European powers and Japan, which might exclude American commerce there.

Bishop Brent and Dr. Hamilton Wright were instrumental in organizing the first international drug conferences (1909, 1912), from which emerged proposals for an international supervisory force to execute the opiate agreements, stamp out the alleged opiate epidemic in Asia, and (in President Roosevelt's words) "protect the savages and uncivilized races in Africa and all parts of the world." Brent, Wright, and others propagandized in the United States against the menaces of opium, addicts, orientals, and aboriginals. Such propaganda and policies did

meet some resistance. For example, a number of the missionaries testifying before the 1903 U.S. Philippine Commission Committee to investigate the use of opium in the Far East, insisted that most Chinese who used opium did so in moderation and that its effects were less harmful than alcohol. Similarly, insurance executives testified that they found moderate smokers acceptable risks. "The United States Consul at Nanking, Mr. W. Martin, stated that men of wealth used opium for a lifetime without ill effects of any kind. Reverend Timothy Richards, in China for thirty-three years, testified that many Chinese use opium as moderately as people in the United States do tea or coffee. Doctors and business men generally agreed in their testimony that moderate use was frequent and abuse... was no greater than abuse of alcohol in America and Europe" (Blum 1969:50).

These and other objections were ignored or overruled. As plans were made for the Shanghai Conference of 1909, however, concern grew over the embarrassing fact that the U.S. itself did not have national legislation to deal with trade in opium. Legislation seemed necessary to save face at the Conference. Hamilton Wright asserted the dangers of opiates in the United States with racial slurs that associated drug use with minorities. Wright's efforts to secure domestic anti-narcotic legislation before the Conference were successful. In February 1909, on the eve of the Shanghai Opium Conference, the U.S. prohibited the importation of opium for nonmedical use. Bishop Brent was chosen as chair of the conference, which ended with a resolution to promulgate international control everywhere. Late in the year, Wright urged control of the drug traffic through federal taxation. Importation into the United States of opium that had been prepared for smoking was banned altogether in 1909. The Foster Bill, the direct antecedent of the Harrison Act of 1914, was drafted by Wright and submitted to Congress. The bill called

for uncompromising controls over the opiate trade. It immediately ran into trouble with those who feared the precedent of federal assumption of police powers formerly reserved to the states. It also was attacked by druggists as a threat to the everyday routine and sales in the drug trade.

Wright and others intensified their campaign to stress the evils of opium. The mythology of the Drug Fiend, the Demon Drug, and the Demon Doctor began to take shape (Kramer 1976:390). By 1914, 27 states and cities had enacted laws against opium smoking, but importation continued to increase. An additional federal statute imposed a prohibitive tax of $400 per pound on opium prepared in the U.S. and, later, the Harrison Act of 1914 increased penalties even further, in parallel with international drug policies. So successful was the campaign of Wright and others that not only were rigid laws passed, but the demonic perception of drug use came to be accepted as reality and, indeed, became a legal fact as new laws ipso facto turned drug users into criminals (Kramer 1976:390).

The Harrison Act ostensibly was a tax measure designed for the control and orderly marketing of opium, morphine, heroin, and other drugs in small quantities over the counter, and in larger quantities by physicians' prescriptions (Brecher et al. 1972:47). However, the constitutionality of the Act was challenged in Congress on the grounds that its appearance as a revenue measure was a subterfuge to permit federal control of matters traditionally reserved to the states. Congress could find nothing in the U.S. Constitution giving it the power to prohibit the use of drugs, argued critics, so it mandated a tax measure instead (Zentner 1975:99-100). By contrast, advocates of the Harrison Act hoped that if the Act were presented as a fulfillment of an international treaty obligation the opposition in Congress would be muffled. Moreover, Supreme Court decisions during this period were expanding federal powers in commerce and taxation,

thus enabling the use of federal police to suppress certain substances under the guise of regulating tax or interstate commerce.

The three central parts of the Harrison Act stated that (1)anyone engaged in the production or distribution of narcotics must register with the federal government and keep records of all transactions with drugs; (2) all parties handling the drugs through production, purchase or sales must pay a tax; and (3) unregistered persons can purchase drugs only on prescriptions from physicians, and such prescriptions must be for legitimate medical use (Zentner 1975:99-100). The dispensing or distribution of opiates and cocaine was not prohibited to patients of registered physicians in the course of their professional practice.

Both Republican and Democratic administrations viewed the Harrison Act as a sound measure to protect the nation from drug use, which by now was equated with the ravages of addiction. Having already been defined by most Americans as immoral or at least as the cause of wasted lives, the use of opiates had now become criminal. However, as Lindesmith (1965:128) pointed out, before the Harrison Act "there was no significant illicit traffic; criminality and addiction were not linked as they are now; the number of addicts in prison was negligible; and there was no problem of juvenile addiction". After such laws, however, those who continued to use opiates were now defined as criminals, and new users were only those persons willing to break the law. This increasingly created a de facto link between the use of such drugs and social marginality or criminality in general. The extension of U.S. anti-opium policies in the Far East had similar effects, with new users being "young urban males from the slums and from the underworld and its fringes" (Lindesmith 1965:221). Opium use in East Asia had become Americanized.

To summarize, the legal prohibition of opium for nonmedical purposes occurred in the United States at a time of great social conflict between immigrant minority groups and the nativist white Protestant society (Helmer 1955:19-33; Gusfield 1980), especially in the Western states. The turn of the century in America was an era of rapid economic growth, great class inequalities, huge waves of immigration, and Progressive reform. Narcotics legislation was part and parcel of the period's wide-ranging impetus for reform and expanded legislation at the state, national, and international levels. The politically articulate middle class hoped that the government could change or neutralize the habits of lower status or more recently immigrated groups by well-written legislation and honest enforcement (Hofstadter 1955). Working class nativists sought protection from what they saw as unfair competition by foreign laborers. Opium use increasingly became identified with white slavery and organized crime, especially Chinese criminal tongs. Difference in drug preferences came to symbolize the difference between groups. For example, opium (when smoked) was associated with Chinese, marijuana with Mexicans, cocaine with blacks, and alcohol with non-Protestant immigrants from Ireland and Southern and Eastern Europe. Substances favored by weaker dissident groups that were economically or politically threatening were labeled as drugs rather than foods, and then as dangerous, toxic, or "non-medical" drugs that should be prohibited.

Moreover, as in England, there was concern over the toxic and addictive effects of opiates improperly taken. The first federal regulatory law, the Pure Food and Drug Act of 1906, was principally directed at protecting unwary users of patent medicines from becoming habituated. Yet, thereafter, government officials began attacking opium as the Demon Flower and its users as Dope Fiends. Efforts were directed by nativist reformers to repress the drug and regulate the

ethnic community known to be users. Thus the concerns that developed over opium smoking by Chinese played a prominent role in the passage of anti-immigration and anti-narcotic legislation culminating in the federal Harrison Act of 1914, the Prohibition Amendment of 1917, and the Immigration Act of 1924.

International political and economic factors also were important. The persons who created the new drug policies instituted in the Philippines and China at the turn of the century also were central figures in creating federal anti-drug laws and enforcement policies within the United States (McNamara 1973:15-21; Musto 1973). The international drug treaties, spurred by a handful of crusaders as a response to their fantasized oriental drug problem, were then used to justify the Harrison Act in America. It was not "police and public concern over the domestic drug problem that... eventually produced the present approaches to, and stereotypes of addiction. [Rather,] law enforcement joined the bandwagon only after the tune had been written and the march begun. The impetus for this anti-opium legislation came from the American Christian missionary societies in China" (McNamara 1973:15-21), who acted unwittingly as ideology workers for the political and economic interests of a racist American labor movement, American imperialism in the Far East (and Latin America), and the nascent U.S. pharmaceutical industry.

What can we learn from the history of opium policy in the United States? Perhaps this case highlights some limits in conventional theories of drug regulation and suggests several alternative hypotheses. Many attempts to explain the origins of America's first major national drug law -- the Harrison Act of 1914 -- assume the order model of public policy and thereby focus on the toxic properties of opiates or the dangerous consequences of their use. Such explanations point to three circumstances: massive morphine addiction resulting from the

treatment of diseases, diarrhea, and wounds during the Civil War; wide-spread opium smoking resulting from Chinese immigration in the last third of the 19th century; and enormous addiction due to the unchecked use of opiates in patent medicines.

Let us consider these explanations one by one. The first factor is not supported by either logic or the historical record. First, "soldier's disease" was not considered a major social problem at the time, and therefore is not much discussed in our case materials. Addicted Civil War veterans never served as "carriers" of a dread epidemic, and by 1914 the veterans were aged or deceased (Quinones 1975; Musto 1973). Second, Chinese immigrants often smoked opium, but Chinese communities of the late 1800's were even more isolated than they are now, and most of them acquired their habit after coming to the United States, probably because of demographic patterns of immigration. Third, many patent medicines were laced with opium, along with alcohol, occasional cocaine, some cannabinol, wintergreen, sassafras, and other ingredients. Millions of persons in all regions and walks of life got a lift from such potents. Most people at the time did not view patent medicines and the mild euphoria that they produced as a source of concern. Moreover, "once opium was banned from Patent Medicines there seem to have been no great social consequences...no hordes of people getting desperately ill, no big run on illegal heroin or morphine, no reports of deaths from withdrawal" (Mandel 1973:10). Further, works of the period that deal with patent medicines do not single out any special drug; thus there was no reason to expect that opium would be prohibited any more than sasparillas.

In sum, conventional explanations from the order model seem inadequate, even mystifying. Instead, the sustaining motivations of American opium policies were consistent with the conflict model: to stigmatize and control a threatening minority population; to enhance the

growing international reach of the nation; to morally elevate the status of "respectable" people; and as we will see, to exclude a popular natural substance from competition with manufactured and legally patented pharmaceuticals. Of course, these efforts were only successful in as much as they were spearheaded by actors with enough power and influence to erode positive perceptions of opium and cement its association with lower classes and undesirable elements.

The Rise of Pharmaceuticals and the Suppression of Opiates

There were three major actors that influenced international restriction of opiates through their national governments. In ascending order of importance, these actors were professional groups such as physicians or pharmacists, British and American moral crusaders in the anti-opium movement, and industrial and commercial firms and associations, principally those of the pharmaceutical industry. Although these actors allied with each other on some issues, they were in conflict, or divided by national interest, on others. For example, the British medical profession gave little support to British moral reformers, and British opium monopolists actively opposed them. But the popular British movement against British opium traders received American backing because the U.S. felt that such restrictions would reduce Britain's economic predominance in the Far East (Musto 1973:24; Taylor 1969:30).

Commercial interests and governments of other nations opposed, or allied themselves with, moral movements according to assessments of long range profit efficiency. Thus representatives of Finland consistently sought international regulation of alcohol whereas delegates from France, in defense of its wine industry, consistently opposed such restrictions except, for a time, those on alcohol use by Africans in French colonies. Similarly, the United

States, the major grower of tobacco, opposed restrictions on that substance. Germany, the leading country in drug manufacture early in the twentieth century and the world monopolist of cocaine, "systematically resisted any strong measures that might jeopardize the favored position of its manufacturers" (Taylor 1969:102).

Despite such divisions on specific issues, however, in these international gatherings and organizations one overall policy direction met little opposition. This was the redefinition of traditional or natural substances into the categories of non-medical, recreational, and harmful in their use, and the confinement of the term "medical" to use of synthetic substances manufactured in Western nations. Prior to the last decades of the nineteenth century, natural hypno-sedatives such as alcohol, cannabis, coca and opium had been basic to healing for centuries or millennia, and there was neither a formal distinction between "medical" and "non-medical" practices nor a stigma attached to socially appropriate uses of these substances. The moral condemnation and eventual restrictions on or criminalization of traditional substances and their users changed this dramatically. Along with such moral and legal strictures, little by little traditional substances were replaced by new manufactured ones. For example, the Single Convention required that natural substances whose use was governed by customary social controls must henceforth be consumed only on medical prescription or in the performance of a function that was defined as therapeutic in the terms of Western professional medicine (Reuter 1968). "The new drugs that were introduced with clinical practice differed from the older agents in being synthetic" (Hordern 1968:117), and because they were not stigmatized they were not associated with the misery or criminality of illicit substances. Of course, the strictures against traditional drugs were not always enforced. For example, "In some countries addicts or drug-dependent persons are

included in the category of medicine-takers while in others they are not" (Bruun et al. 1975:83). In general, enforcement of international agreements was left to individual member countries, and ignored entirely by nations that were not members of the early conventions or, later, of the United Nations.

With its successful promotion of the Shanghai Commission of 1909 and the Hague Conference of 1912, the United States became the major activist nation in international drug regulation. Concern about opium grew within the U.S., and Bishop Brent propagandized about opium smoking in the newly acquired Philippines. Further, the United States sided with China against European and especially British commercial interests in hopes of enhanced "opportunities for mutually profitable commercial relations" in the future (Taylor 1969:329).

In the 1920's the U.S. successfully sought to broaden the focus of international regulation from opium to heroin and other non-pharmaceutical "narcotics" such as cannabis, coca leaves, and cocaine. At the Geneva Conferences of 1924-25, for example, the U.S. insisted that the "non-medical" use of opium and other traditional drugs (except alcohol and tobacco) was a moral and social evil; that non-medical production, trade, or use of such drugs was not legitimate; and that world production of such drugs must not exceed the quantity necessary for medical and scientific uses (Taylor 1969:330). This policy continued and became stronger under the influence of Harry Anslinger, the top drug law enforcer in the United States and a chief U.S. representative to international drug control meetings and accords. In the 1930's American drug manufacturers favored sufficient international regulation of pharmaceuticals to bring their European competitors under the same controls as they themselves had been subjected to by regulation within the U.S. (Taylor 1969:243). Overall, however, "the main obstacles to statutory

international control have been the vested interests of the opium monopoly countries in the early phases, and of the drug manufacturing countries in subsequent periods" (Bruun et al. 1975:28; see 43).

At the international level, as in domestic policies, the drugs or drug policies that are attacked have usually been those of poorer or weaker nations -- for example, defeated Germany and Japan in 1946 (where pharmaceutical epidemics were discovered), and less developed countries generally. By contrast, the U.S. is often applauded for all its anti-drug efforts and the mismanagement and ineffectiveness of its drug programs are rarely discussed in international fora. Instead, "it is invariably the developing countries, rather than the rich consuming countries, which are taken to task" (Bruun et al. 1975:141).

The 1972 Report of the United Nations International Narcotics Control Board uses a rhetoric of crisis and control that is reminiscent of Harry Anslinger's or Bishop Brendt's and that continues to characterize discussions of prohibited substances in the United States.

> Humanity is facing a world crisis: a crisis which is portrayed in the spectacular growth of drug abuse; in the revival of the evil in countries where firm action seemed to have succeeded in checking it; in the emergence of new channels of illicit traffic; in the appearance in law respecting countries of group defiance of the law (INCB 1972:34)

The report also focuses on the opiates, cannabis, the coca leaf, and cocaine, and ignores alcohol, tobacco, and pharmaceuticals. Generally, countries that have strong pharmaceutical manufacturing industries favor strengthening the Board when the topic is the eradication or

control of natural substances at their sources, but not in those rare moments when pharmaceuticals are in question (Bruun et al. 1975:86,107-108, 125).

Perhaps such a rhetoric of crisis concerning certain drugs and silence concerning others is related to the composition of International Narcotics Control Board itself. In 1972 the President of the Board was Harry Greenfield, who was closely connected to the British-American Tobacco Company. Other leading figures on the Board have been Otto Anselmino who until 1938 had worked for the pharmaceutical firm Gockecke in Berlin, Harry J. Anslinger, a leading U.S. official in alcohol prohibition in the 1920's and of "narcotic" (especially cannabis) prohibition in the 1930's; and Herbert May, who for 18 years was in his family's pharmaceutical business headquartered in Pittsburgh. More significantly, these and other men of similiar backgrounds were bound by strong ties of friendship and almost all of them, either before and during international service or soon after it, had strong links to the pharmaceutical industry. This "gentlemen's club" also is linked to the World Health Organization (WHO), the International Federation of Pharmaceutical Manufacturers Associations (IFPMA), the International Pharmaceutical Association (IPA), and the Swiss drug firm CIBA-Geigy. An example of such interlocks is the CIBA-Geigy senior executive who represented the IPA to WHO in 1971 and appeared a year later as the IFPMA's representative in the WHO executive Board's listing of non-governmental organizations (EB 47 SR 17:275; Bruun et al. 1975:154). Similarly, the Swiss delegation to the Vienna Conference included executives from the three largest pharmaceutical companies of Switzerland: Hoffman-LaRoche, CIBA-Geigy, and Sandoz. Among U.S. delegates to the 1970 drafting session of the Commission was a representative of the American Pharmaceutical Manufacturers Association (Bruun et al. 1975:155; Cox and Jacobson 1973:178).

The flow of personnel also goes in the opposite direction. Gilbert Yates, a former director of the United Nations Division of Narcotic Drugs, became the Director of the Association of the British Pharmaceutical Industry; Adolf Lande, previously secretary of the INCB, was connected with the American Pharmaceutical Manufacturers Association; and Hans Halbach, a former chief of the WHO Drug Dependence Unit... is now [in 1975] employed by the Swiss drug firm Hoffman-LaRoche" (Brunn et al. 1975:156). Thus the same "iron triangle" and "revolving door" of domestic regulatory agencies exists at the level of international drug regulation, only in this case oligopolies are preserved more ingeniously than usually -- by criminalizing their competition.

In the struggle between natural and pharmaceutical drugs, only pharmaceutical manufacturers have this kind of access. The initial perception of pharmaceuticals as legitimate allows that industry's representatives opportunities to lobby elected officials and influence official policy in ways that, when attempted by purveyors of natural, recreational, and/or illegal drugs, are tantamount to bribery or co-optation.

The limited financial resources and staffing of international organizations that monitor and control drugs also gives great weight to outside groups that are willing (or unwilling) to provide staff work, money, expert testimony, or other resources. Thus, the staffing of the World Health Organization has been ample for opium traffic or "narcotic drugs", weak for pharmaceuticals, and practically non-existent for alcohol (Bruun et al. 1975:60-63). Like most economic sectors that deal in staples, the licit drug industry is highly concentrated, with criminalization of alternative substances providing one barrier against potential competitors. The industry is dominated by a few top firms in Germany, Switzerland and the United States, with

Japan and Russia important in their regional markets. In 1965, of the world's ten largest pharmaceutical companies, seven were American, two were Swiss, and one was Japanese (Breckton 1972:28 and Brunn et al. 1975:157-159). Today the big pharmaceutical firms are more multinational and make more use of local subsidiaries, but the few that control most world market share are still moored in particular core states of the world system. Thus, the U.S. dominance in the pharmaceutical industry may have something to do with the leadership by America in international agreements that suppress the major competing non-Western traditional substances -- opiates, coca and cannabis.

Some firms have claimed to be in favor of controls that would debar their more dubious competitors from the trade, but this would serve also to provide another barrier to entry of competitors within the licit drug trade, as happened with regulation of the railroad and meat-packing industries under legislation during the Progressive Era in the United States (Kolko 1957). For example, the pharmaceutical firms were major purveyors of synthetic opium while the Anglo-Chinese trade was being suppressed. Indeed, their illegal traffic in the Far East in the 1920's constituted "a more serious menace to orientals than the use of prepared opium" (Taylor 1969:231). Major legitimate firms also have been known to aggressively engage in illicit sales of psychotropic drugs. For example, an "estimated 20 percent of all amphetamines are diverted from licit channels; this suggests some collusion on the part of [the drug firms] in charge... Perhaps attention is concentrated on the well-organized professional criminal for the reason that [attention on] the other elements involved [would] raise awkward questions" (Bruun et al. 1975:236,241). One should also mention the massive legal overuse that has been stimulated by advertising and other marketing devises of the licit drug industry. In sum, throughout this

century when efforts have been made to bring the non-medical or therapeutically inappropriate use of pharmaceuticals to the attention of international bodies such initiatives have been actively contested and rejected. And when the rare attempt has been made (e.g. by a Third World country or by Sweden) to propose even mild international regulation on the improper use of pharmaceutical drugs, the manufacturers, their associations, and their governmental representatives have vehemently and successfully resisted. By contrast, these same actors have been a major and consistent force in the criminalization of opium and other traditional drugs that might compete with drugs made by the major pharmaceutical companies themselves. The extent of the pharmaceutical industry's influence on public policies and perceptions is taken up in greater detail in chapter 8.

Toward Some Conclusions

We have seen an interaction of economic, political, and ideological forces in the shaping of opium policies at both the national and international levels. One sustaining motivation of policies related to opium appears to be the control and enhancement of profit. Thus, a theory of capitalist development is implied in our analysis of drug policies that derives from Marx, Weber, Schumpeter, and Wallerstein—a theory of commoditization of traditional substances, their repression and replacement (except for alcohol and tobacco) by manufactured drugs, economic rationalization for long term profit, the use of state power to suppress or manage competition, and a shift of locus from nations to a global political economic system.

Our findings also suggest that there is a "long cycle" of drug policy formation, as these policies appear to stay in place for many decades. Hence, several generations, rather than several

legislative sessions, is the proper horizon for studying changes in drug policies, thereby calling for a comparative *historical* analysis and a long view of possible policy changes.

Another hypothesis that our data suggest is that restriction of a given drug may be used as a device to regulate or repress a minority community. This is far from a universal phenomena, however. Indeed, in the cases that we examined, drug regulation as a vehicle for minority repression appears only in the United States. Perhaps this is due to two factors: the universalistic character of the American legal system and the rapid increase in ethnic diversity and competition between ethnic groups in the United States in the crucial period between 1870 and 1920. Unlike the colonial or imperial rule of British India or Imperial China, laws in America in principle are to apply to all persons equally. This is true of England as well, but unlike England, the United States during the period of rapid transformation of drug laws also was subject to extreme racial and ethnic tension due to large-scale industrialization and immigration. In such a situation, the mobilization of state power by one group against another could not easily be explicitly targeted at, say, the Chinese. Instead, minority repression could be achieved indirectly through laws against a particular practice favored by a certain group, rather than directly by explicitly targeting that group. Thus anti-immigration laws were passed against Chinese *foreigners*, whereas laws against opium smoking (but not drinking, since middle and upper class whites were still fond of opium-laced patent medicines) were against Chinese *citizens* and legal residents of the United States.

Anti-opium laws also were passed in ethnically diverse and democratic post-Independence India, but in India this was not part of a widespread moral campaign directed against particular ethnic groups. How might this be explained? The indifference of drug laws in

India to particular ethnic or caste groups may be due to several factors: Indians generally accept multi-ethnicity as a basic fact of their national existence; they do not have a strong egalitarian ethic; and Indians tend to handle their affairs (including discrimination) through informal rather than legalistic devices. Though officially and formally democratic, Indian culture is not egalitarian and India's hierarchic order is sanctioned by custom and tradition. Thus subordination of one group by another could be effected openly, even violently, without indirect legal devices.

We also can see in our cases several broad alternative drug policies (or non-policies) of the state. These include first, the condition of no formal policy at all, as with opium drinking in traditional India or in mid-nineteenth century England and the United States. A second policy is a state-regulated monopoly organized to maximize revenue, as in Mogul and British India and the Spanish Philippines. A third policy alternative is medicalization of opium use, as in twentieth century Britain and post-Independence India. Finally, there is what might be called the American option, criminalization.

Still another observation that emerges from our examples is that cultural factors influence the ordering of behavior and the reception of policies related to opium, and perhaps to drugs in general. In the case of India, opium use had been fully integrated into religious, commercial, and social aspects of life for centuries, and there were well-established informal norms and sanctions enforcing temperate use of that substance. Moreover, neither the drug nor those who used it appropriately were stigmatized, and the Indian government's method for reducing drug use was largely to withdraw the supply rather than to stigmatize use or users. In the cases of Britain and the United States, as with other Western nations, potents and medicinals had been taken for centuries -- opium was simply the newer and better version of traditional draughts. Opium

smoking, however, was new and different, and this may have rendered it more open to negative definition and intemperate use.

Our cases also suggest that public health factors (which order theorists advance as *the* casual engine of drug policies) can indeed play a role, as in the public demands in England and America that the contents of medications be accurately labeled and that opiates not be used for children. The public's awareness of toxic dangers of opiates and other drugs did not depend on any sophisticated medical knowledge, of course, but it certainly was rational in understanding that honesty in labeling could help prevent fatal overdoses. Notice, however, that these movements were not against opium or opium use per se, but only against the deception of consumers by purveyors.

Our data also may offer some insight into the conditions of success or failure of attempts to reduce the consumption of a particular substance. In Britain and post-Independence India, policies of medicalization worked fairly well. Criminalization, as in the United States, also has reduced consumption, but at much greater direct economic and indirect social costs. The policies of Britain and India "created" a greater public health problem insofar as continuing users were redefined as patients. But in both countries the medical availability of opiates largely thwarted the growth of an alternate illicit traffic in these substances. By contrast, the policy of criminalization of the United States created both a criminal *and* additional public health problems. The criminal problem comes from the creation of a criminal class of users, dealers, growers, and corrupt officials; the health problem comes from impurities of the product and the unsanitary conditions of their illegal use, both generated by their criminal status.

China also sought to criminalize opium use in the nineteenth century and again after the 1949 victory of the Chinese Communist Party. The first effort was a disastrous failure, the second an extraordinary success. How can we account for the difference? In the earlier instance, there was little popular interest in suppressing the drug, and gentry and merchant groups had strong interests in its purveyance. Moreover, the central government was in administrative decline, was losing legitimacy, and was facing not only internal resistance but also the overwhelming organizational and military superiority of the British and other powers. China was attacked not by horsemen from the North, for which it had been prepared by many centuries of incursions, but by gunboats from the South, of which it could hardly conceive. By contrast, the Chinese Communist Party in 1949 had widespread legitimacy as the party of the people and the victors over the invading Japanese; and the CCP also had an organizational structure that in principle and eventually in practice reached down to every village and neighborhood. Moreover, opium was seen by most Chinese as a corrupting poison brought in by the Western barbarians. To be against opium was to be for Chinese independence from foreign rule. Thus, a broadly legitimate and efficiently authoritarian government drew on enthusiastic popular support to successfully suppress opium use through criminal sanctions. The sanctions of prison or death still exist; but with the recent economic, political, and ideological opening of China there is less identification of opium with Western imperialism, less legitimacy and pervasiveness of the current governmental apparatus, and a corresponding diffusion of local decision-making, including individual sensory freedom. Thus the use of opium and other illegal substances appears to be rapidly rising. Like other phenomena in the People's Republic, China's drug problem may become "Americanized".

Perhaps there is one further intuition that we can draw from our materials. Groups with interests in one drug may compete politically with groups having interests in other economically competing substances. This seems clear enough in our discussion of the efforts of the new pharmaceutical industry to suppress traditional substances such as opium that competed with its manufactured substances. We might further speculate that certain drugs are linked together in their physiological effects or mode of ingestion -- for example, nicotine and cannabis both are typically ingested through cigarette smoking, amphetamines and cocaine are both "uppers"; alcohol and opiates both sedate. To the extent that such pairs of substances compete directly with each other in the marketplace, the suppression of one might be a way of enhancing market share for its counterpart, and thereby may have motivated state policies of promotion or prohibition. Such ideas, and others, might be refined and elaborated empirically by examining further cases of drug policy formation. In any case, it does seem clear that the conflict model of policy formation better explains the commonalities and differences in our cases on opiates than the order model. As the data show, political and economic factors have been far more influential across the history of opium policy than any rational, scientific concerns for public health and safety, a situation that remains largely unchanged today.

BIBLIOGRAPHY

Archibald. 1970. "School and Drugs: Government Responsibility." In Elizabeth D. Whitney, ed. World Dialogue on Alcohol and Drug Dependence. Boston: Beacon.

Blum, _____. 1969. Society and Drugs: Social and Cultural Observation. San Francisco: Jossey-Bass.

Bonnie, Richard J. and Charles H. Whitehead, II. 1974. Marihuana Conviction: A History of Marihuana Prohibition in the United States. Charlottesville: University Press of Virginia.

Brecher, Edward M. and the Editors of Consumer Reports. 1972. Licit and Illicit Drugs. Boston: Little, Brown.

Breckton, William. 1972. The Drug Makers. London: Eyre Methuen.

Brill, _____. 1973. "The Treatment of Drug Dependence: A Brief History." In Drug Use in America: Problem in Perspective 4 vols. Washington DC: U.S. Government Printing Office.

Bruun, Kettil, Lynn Pan, and Ingemar Rexed. 1975. Gentleman's Club: International Control of Drugs and Alcohol. Chicago: University of Chicago Press.

Carson, Gerald. 1961. One for a Man, Two for a Horse. New York: Bramhall House.

Chang, Hsin-pop. 1964. Commissioner Lin and the Opium War. Cambridge MA: Harvard University Press.

Chesneaux, Jean, Marianne Bastid, and Marie-Claire Bergere. China from the Opium Wars to the 1911 Revolution. New York: Random.

Chopra, R.N. and I.C. Chopra. 1955. "Quasi-Medical Use of Opium in India and its Effect." Bulletin of Narcotics.

_____. 1957. "Free Treatment of Drug Addiction: Experience in India." Bulletin on Narcotics 22-33.

Cox, Robert W. and Harold K. Jackobson. 1973. The Anatomy of Influence: Desicion-Making in International Organizations. New Haven CT: Yale University Press.

Dane, _____. 1895. "Historical Memorandum." In Final Report of the Royal Commission on Opium.

Dillion, _____. 1962.

Duster, Troy. 1970. The Legislation of Morality: Law, Drugs, and Moral Judgement. New York: Free Press.

Edkins, _____. 1894. "Opium: Historical Note, or the Poppy in China." In First Report of the Royal Commission on Opium.

Elvin, Mark. 1973. The Pattern of the Chinese Past. Stanford: Stanford University Press.

Fay, Peter Ward. 1975. The Opium War, 1840-1842. Chapel Hill: University of North Carolina Press.

Fields, and Tarrarin. 1970. "Opium in China." British Journal of Addictions.

Guerra, _____. 1974. "Sex and Drugs in the 16th Century." British Journal of Addictions.

Gusfield, Joseph. 1980. Symbolic Crusade: Status Politics and the American Temperance Movement. Urbana: University of Illinois Press.

Hawks, D.V. 1974. "Epidemiology of Narcotic Addiction in the United Kingdom." In Eric Josephson and Carroll, Drug Use: Epidemiological and Sociological Approaches. Halsted.

_____. 1971. "Dimensions of Drug Dependence in the United Kingdom." International Journal of Addictions.

Hayter, Althea. 1968. Opium and the Romantic Imagination. Berkeley: University of California Press.

Helmer, John. 1975. Drugs and Minority Oppression. New York: Seabury.

Helmer, John and Thomas Victoria. 1974. Drug Use, the Labor Market, and Class Conflict.

Hill, _____. 1973. "Anti-Oriental Agitation and the Rise of Working-Class Racism." Society.

Hofstadter, Richard. 1955. The Age of Reform: From Bryan to F.D.R. New York: Knopf.

Holbrook, Stewart. 1959. The Gold Age of Quackery. New York: MacMillan.

Holt, Edgar. 1964. The Opium Wars in China. Chester Springs PA: Dufour.

Hordern, Anthony. 1968. "Psychopharmacology: Some Historical Considerations". In L.R. Joyce, ed. Psychopharmacology: Dimensions and Perspectives. London: Tavistock.

Inglio, Brian. 1975. The Forbidden Game: A Social History of Drugs. New York: Scribner.

International Narcotics Control Board. 1972. INCB Report. New York: United Nations.

Johnson, _____. 1975. "Understanding British Addiction Statistics." Bulletin of Narcotics.

_____. 1975. "Righteousness Before Revenue: The Forgotten Moral Crusade Against the Indo-Chinese Opium Trade." Journal of Drug Issues.

Josephson, 1973. "British Response to Drug Abuse." In Drug Use in America. Appendix 5.

King, Rufus. 1972. The Drug Hangup: America's Fifty-Year Folly. Springfield IL: Thomas.

Kohli, 1976. "The Story of Narcotics Control in India." Bulletin on Narcotics 3.

Kolko, Gabriel. 1957. The Triumph of Conservatism. A Reinterpretation of American History 1900-1916. Chicago: Quadrangle.

Kramer, 1977. "Heroin in the Treatment of Morphine Addiction." Journal of Psychological Drugs.

_____. 1976. "From Demon to Ally - How Mythology Has and May Yet." Journal of Drug Issues.

_____. 1972. "Controlling Narcotics in America: Medicine or the Law." Drug Forum.

Lindesmith, Alfred. 1968. Addiction and Opiates. Chicago: Aldine.

_____. 1965. The Addict and the Law. Bloomington: Indiana University Press.

Lomax, Elizabeth. 1973. "Uses and Abuses of Opiates in Nineteenth Century England." Bulletin of the History of Medicine 47, 2, 167-176.

Lowes, Peter. 1966. The Genesis of International Narcotics Control. Geneva: Librairie Droz.

Lyman, Stanford M. 1977. The Asian in North America. Santa Barbara CA: Clio Press.

Mandel, Gerald. 1973.

Mark, Gregory Yee. 1975. "Racial, Economic, and Political Factors in the Development of America's First Drug Laws." Issues in Criminology.

McNamara, Joseph. 1973. "The History of United States Anti-Opium Policies." Federal Probation 5, 37 (June) 15-21.

Miskel. 1973. "Religion and Medicine: The Chinese Opium Problem." History of Medicine and Allied Sciences.

Morrell, _____. 1973. Maintenance of Opiate Dependent Persons in the United States: A Legal Medical History.

Morrison, Samuel Eliot. 1965. The Oxford History of the American People. New York: Oxford University Press.

Musto, David. 1973. The American Disease. New Haven CT: Yale University Press.

Owen, David Edward. 1969. Commissioner Lin and the Opium War. Cambridge MA: Harvard University Press.

_____. 1934. British Opium Policy in China and India. Hamden CT: Anchor.

Quinones, Mark A. 1975. "Drug Abuse During the Civil War." International Journal of Addictions 10, 6.

Reuter, Paul. 1968. "The Obligation of States under the Single Convention on Narcotic Drugs." Bulletin on Narcotics.

Sasz, Thomas. 1975. Ceremonial Chemistry: The Ritual Persecution of Drugs, Addicts and Pushers. Garden City NY: Anchor.

Schur, Edwin M. 1968. Narcotic Addiction in Britain and America: The Impact of Public Policy. Westport CT: Greenwood.

Sears Roebuck. 1902. Catalogue (Section on Patent Medicine).

Shukla, _____. 1970. "A Note on Drinks and Drugs in Historical Perspective." Eastern Anthropologist 299-306.

Simmons, Luiz, R.S. and Martin B. Gold. 1973. "The Myth of International Control: American Foreign Policy and the Heroin Traffic". International Journal of Addictions 8, 5, 779-800.

Spear, _____. 1975. "British Experience." John Marshall Journal of Practice and Procedure.

Spear, and Glatt. 1971. "Influence of Canadian Addicts on Heroin Addiction in the United Kingdom." British Journal of Addictions.

Taylor, Arnold. 1969. American Diplomacy and the Narcotics Traffic, 1900-1939. Durham NC: Duke University Press.

Terry, Charles Edward and Mildred Pellens. 1970. The Opium Problem. Montclair NJ: Patterson Smith.

Young, James Harvey. 1967. The Medical Messiahs. Princeton NJ: Princeton University Press.

_____. 1961. The Toadstool Millionaires: A Social History of Patent Medicines in America Before Federal Regulation. Princeton NJ: Princeton University Press.

Zentner. 1975.