

**“There is a new drug in the schedule”: The Mysterious Origins of
Criminalized Cannabis**

By

Nathan Ruston

Supervised by

Dr. Penny Bryden

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Table of Contents

Introduction: The Mysterious Origins of Criminalization	1
Cannabis: A Brief History	4
Medical Authority and the Development of Addiction	11
The 1920s Drug Panic: Moral Reformers and Legislators	18
Revisiting the Mystery: Testing the International Theory	28
Conclusion	38
Bibliography	41

Introduction: The Mysterious Origins of Criminalization

In summer 2018, Canada is set to legalize the recreational use of cannabis. This will mark the end of almost a century of prohibition, yet the origins of criminalized cannabis remain shrouded in mystery. In a 2014 CBC article titled “Marijuana was criminalized in 1923, but why?” the author notes that “if there was any kind of parliamentary debate, historians have been unable to find a record of it.”¹ A 2002 Senate report on cannabis recognizes that “when cannabis was introduced in the legislation on narcotics in 1923, there was no debate, no justification, in fact many members did not even know what cannabis was.”² Cannabis was criminalized in an amendment to the Opium and Narcotic Drugs Act in 1923, and Canada was the first government in the West to do so (barring a handful of the southern states in the U.S.). This was done despite the fact that there was essentially no psychotropic use of it in Canada at that time.³ The dearth of historical evidence and explanation exists despite the efforts of a number of historians. In the painstakingly detailed history of Canadian drug policy, *Panic and Indifference*, the authors note that the original drafts of the bill that criminalized cannabis did not initially include it in the amendments. It was only on a carbon copy of the draft that an unknown person added the drug to the schedule of prohibited substances.⁴ Even with this piece of information, they, like everyone else, remain at a loss to explain how or why cannabis was added at all. The lack of official justification has spawned multiple theories and much speculation.

¹ Daniel Schwartz, “Marijuana was criminalized in 1923, but why?” *CBC News*, May 6, 2014, <http://www.cbc.ca/news/health/marijuana-was-criminalized-in-1923-but-why-1.2630436>, (accessed 14 March 2018).

² Canada, Senate, *Cannabis, our position for a Canadian public policy: Report of the Senate Special Committee on Illegal Drugs, Summary Report*, 2002, 22.

³ Catherine Carstairs, *Jailed for Possession: Illegal Drug Use, Regulation, and Power in Canada, 1920-1961* (Toronto: University of Toronto Press, 2006), 31.

⁴ P.J. Giffen, Shirley Endicott, and Sylvia Lambert, *Panic and Indifference: The Politics of Canada’s Drug Laws* (Ottawa: Canadian Centre on Substance Abuse, 1991), 179.

One common theory posits that Emily Murphy, a popular moral reformer in the 1920s, was responsible for criminalization. This is because in 1922 she published a book, titled *The Black Candle*, in which she vilifies the effects of cannabis and the behaviour of its users. Both cannabis activists and scholars have subsequently blamed her work for criminalization: “she drew the attention of the Canadian authorities” to the drug, and “cannabis wound up added to Canada’s anti-drug law a year after *Black Candle*’s publication.”⁵ However, Catherine Carstairs, who has written extensively on the racist origins of Canada’s early drug policies, has argued both in the media and in her academic work that Murphy’s book was relatively unpopular when it was published, and that “the Division of Narcotic Control had little respect” for her by 1923.⁶ Carstairs’ criticism is particularly compelling, because advocates that blame Murphy’s work have failed to produce a direct link between her publication and the subsequent legislation.

Alternatively, Carstairs points to Canada’s participation in international drug control conferences as a possible cause for criminalization.⁷ International drug control was a relatively new phenomenon in the early 20th century, with the first major drug control conference held in Shanghai in 1909. The debates in Shanghai centred on controlling the import and export of opium internationally, with other drugs, such as cocaine and morphine, entering the agenda at subsequent meetings. Prior to its criminalization, cannabis was discussed on one occasion at these meetings: The Hague Opium Conference in 1911 and 1912. Carstairs views this

⁵ Martin Booth, *Cannabis: A History* (New York: St. Martin’s Press, 2003), 167; Joshua Ostroff, “The Mother of Canada’s Marijuana Laws Is a Feminist Hero and a Racist Monster,” *Vice*, 23 November 2017, https://www.vice.com/en_ca/article/3kvgg8/the-mother-of-canadas-marijuana-laws-is-a-feminist-hero-and-a-racist-monster.

⁶Catherine Carstairs, “Deporting ‘Ah Sin’ to Save the White Race: Moral Panic, Racialization, and the Extension of Canadian Drug Laws in the 1920s,” *Canadian Bulletin of Medical History* 16, no. 1 (1999): 71; Catherine Carstairs, “How pot-smoking became illegal in Canada,” *Conversation*, 15 March 2018, <https://theconversation.com/how-pot-smoking-became-illegal-in-canada-92499>.

⁷ Carstairs, “How pot-smoking became illegal,” <https://theconversation.com/how-pot-smoking-became-illegal-in-canada-92499>.

conference as evidence that “controlling cannabis had been under international discussion for more than a decade” by the time it was criminalized in 1923, but it was absent from international debates in the intervening years.⁸ Cannabis was addressed in greater detail by the drug control agencies of the League of Nations, but the impact of those debates upon Canada’s criminalization of the drug remains questionable.

The only thing that does seem clear is how little is known about the origins of criminalization. Some of the most recent academic publications on drug prohibition have been content to recognize that cannabis “was added to the schedule with no debate or evidence that it was a dangerous drug,” before simply moving on.⁹ However, the scholarship on the criminalization of cannabis has neglected several key historical trends and events in attempting to understand it. One glaring issue is the fact that Canadian officials failed to reference the broad body of knowledge on the sociological and medical effects of cannabis use that was available by 1923. British imperial and medical authorities had studied the drug extensively in India throughout the 1800s, yet none of this information was utilized by Canadian officials.

Additionally, when cannabis was criminalized the Canadian public was embroiled in a nation-wide drug panic that was rooted in contemporary racist sentiments. Moral reformers generated this panic regarding drug addiction by presenting it as a threat to the moral and racial integrity of the nation. This threat was largely constructed upon definitions of addiction that had been developed by the professionalizing medical community over the course of the 19th century. The terms on which addiction was understood resulted in an emphasis on the immorality of the user, which obfuscated the differences between drugs and allowed them to be treated as a

⁸ Carstairs, “How pot-smoking became illegal,” <https://theconversation.com/how-pot-smoking-became-illegal-in-canada-92499>; Mills, *Cannabis*, 157.

⁹ Susan Boyd, *Busted: An Illustrated History of Drug Prohibition in Canada* (Winnipeg: Fernwood Publishing, 2017), 54.

uniform problem. In order to understand the criminalization of cannabis, it needs to be situated in relation to the contemporary definitions of addiction and the drug panic of the 1920s. These trends help in understanding the dual failure of the Canadian government's role in criminalization; both in the lack of justification for their decision to do so, and in their failure to utilize the knowledge available about cannabis at that time.

Cannabis: A Brief History

As a drug, cannabis has been cultivated and traded for both its psychoactive and non-psychoactive properties throughout human history. It was consumed medicinally, recreationally, and religiously in Asia and the Middle East for millennia, while hemp paper and textiles have been used in Europe and North America since the 5th century.¹⁰ It also enjoyed a brief period of popularity as a medicine in Western society during the 19th century, largely as a result of the British imperial administration in India. This administration studied cannabis extensively, both sociologically and medically, and produced a large body of knowledge on cannabis before it was replaced by more potent, and more dangerous, remedies, such as opium, cocaine and morphine. The first major instance of Western contact with cannabis followed the acquisition of a financially floundering East India Company by the British parliament, through the 1773 Regulating Act and 1784 India Act. Having acquired the East India Company, the British government needed to prioritize fiscal returns on its newly-obtained British interests in India.¹¹

¹⁰ Martin Booth, *Cannabis: A History* (New York: St. Martin's Press, 2003); Chris Duvall, *Cannabis* (London: Reaktion Books, 2015); Robert C. Clarke and Mark D. Merlin, *Cannabis: Evolution and Ethnobotany* (Los Angeles: University of California Press, 2013). For more information on the pre-colonial history of cannabis in Asia and elsewhere, Duval and Clarke offer thorough studies. Additionally, Booth presents a useful survey of medieval and early modern European hemp usage for those interested.

¹¹ Booth, *Cannabis: A History*, 75.

As a result, a series of taxes were introduced, including a tax on cannabis in 1790. This would mark the beginning of over a century of British administration of legal cannabis sales and use.¹²

This administration operated within a culture that both used and produced cannabis extensively. During the 1800s, India was simultaneously “the world’s largest producer of, and market for, cannabis narcotics.”¹³ The plant played an important role in the farming practices of farmers in these regions and required extensive land management, as well as intensive labour at multiple stages in planting, tending, and finally harvesting it. In short, “the whole process of cultivating hemp for narcotics... shaped the ecology and society of the areas in which it was an important part of the economy.”¹⁴ These crops were of indispensable value to many farmers, but the cultivation process also spawned cultural practices that transcended local religious differences; in certain areas where there were both Hindu and Muslim farmers, members of both religious groups celebrated weddings at the same time: after they sold their cannabis crops.¹⁵ After harvest, farmers would store their crops and sell them to wholesalers as demands required. The wholesalers would then distribute the produce to dealers operating both within India and abroad. Cannabis was a cash crop that played an important role in regional social, cultural, and economic practices in India, and it was upon this system that the British attempted to establish a taxation policy.

While British colonial authorities were well aware of Indian cannabis production and use, they were primarily concerned with the collection of taxes on cannabis crops, and thus were

¹² James Mills, *Cannabis Britannica* (New York: Oxford University Press, 2003), 3.

¹³ Ibid., 48.

¹⁴ Ibid., 55.

¹⁵ Ibid., 56.

relatively unconcerned with the nature of the drug itself.¹⁶ As a result, they remained only vaguely aware of the intoxicating properties of cannabis in the early 18th century. In the early colonial administration of India, it was the medical personnel of that administration that were most interested in studying cannabis drugs. Generally, these early treatments of cannabis “were written by men whose religious and moral commitments meant that they saw the plant’s intoxicating properties as a potential source of sin.”¹⁷ These doctors would be the first of many whose positions on intoxicating drugs would be influenced by Christian temperance sentiments, but these works were not widely published. Additionally, not all of the work produced by British medical professionals was so evidently biased, and some had a major impact on the international medical community and industry.

One important exception to the moralizing work of early 19th century doctors was Dr. William Brooke O’Shaughnessy, who published a book titled *The Bengal Dispensatory and Companion to Pharmacopoeia 1842*. With twenty-five pages dedicated to cannabis, but only a sentence or two acknowledging its recreational use in Eastern societies, O’Shaughnessy’s *Dispensatory* played a major role in legitimizing cannabis as a treatment option for a variety of illnesses.¹⁸ His work “led cannabis to spread rapidly through Western medicine in both Europe and into North America.”¹⁹ This represented a remarkable shift in the attitudes of the medical community towards cannabis, and was a major departure from the Christian temperance sentiments that had coloured previous works on the medical value of the drug.

¹⁶ Ibid., 19. At this point, Britain was still in desperate need of these raw materials for the manufacturing of ship cordage and sails. They had in fact already attempted to encourage production of hemp fibre both domestically and in other imperial entities, including Canada.

¹⁷ Ibid., 37.

¹⁸ Ibid., 42-45.

¹⁹ Andrew Hand et al., “History of Medical Cannabis,” *Journal of Pain Management* 9, no. 4 (2016): 389.

For a period of a few decades immediately following the publication of O'Shaughnessy's work, there was a burst of enthusiasm for cannabis as the new "wonder drug." A number of medical journals jumped to publish articles describing a broad array of symptoms and illnesses that could be treated with it. While the scientific value of these works is questionable, the therapeutic application of cannabis was highly popular in the 1850s and 1860s.²⁰ It even gained popularity in North America, particularly after rumours spread that Queen Victoria's physician-in-ordinary, Sir John Russell Reynolds, had prescribed it to her to relieve menstrual cramps.²¹ While this is difficult to confirm, Reynolds did publish an article in *The Lancet* in 1890, which declared that cannabis was "one of the most valuable medicines we possess."²² A flurry of patent medicines, all claiming to cure a host of ailments and containing cannabis tinctures, were produced both in Britain and the United States. For a brief period of time, from approximately 1850 to 1890, cannabis drugs enjoyed a surprising degree of patent medicine popularity and enthusiasm from the medical community. There were indeed some benefits to cannabis; Booth argues that doctors preferred it to opium due to its lack of addictive qualities and other negative side effects.²³ For a moment, then, cannabis enjoyed a degree of acceptance in the West, but this would quickly come to an end.

By the end of the 19th century, several factors caused the medical use of cannabis to fall from favour. In North America and Europe, difficulties in obtaining an exact dosage, the inability to inject it directly, and the rise of synthetic drugs made it simply less practical than

²⁰ Mills, *Cannabis*, 71-73. Sometimes, the conclusions were contradictory. in the 1850s the *Edinburg Monthly Journal of Medical Science* published an article claiming that cannabis could stimulate contractions in a pregnant woman, but nearly simultaneously the *Provincial Medical and Surgical Journal* published an account claiming that cannabis had delayed the delivery of a child for almost two months.

²¹ Booth, *Cannabis: A History*, 114.

²² Ibid.

²³ Ibid., 113.

other choices.²⁴ As cannabis became medically obsolete, its reputation also suffered from systematic inaccuracies in the documentation of insane asylum cases in India. Due to the assumption that drug use could result in a “moral insanity” of sorts, and the bureaucratic necessity of filling in an instigating factor for the patient’s lack of sanity, many cases in which the patient was unresponsive, incoherent, or otherwise unable to communicate a cause for the deterioration of their mental health placed the blame upon cannabis use.²⁵ These resulted in the formation of a highly questionable and mostly unfounded link, that was nevertheless supported by India’s national statistics on asylums, between insanity and cannabis drug use, to the extent that in the 1870s 33% of insanity cases in one regional asylum were attributed to the drug.²⁶ These statistics, despite their faulty nature, were the basis of the authoritative and supposedly scientific conclusion that cannabis use led to insanity, which conformed with the broader contemporary conceptions of intoxicants, such as opium, as social and moral evils.²⁷ What is clear is that over the course of the second half of the 19th century, cannabis first emerged and then declined in popularity as a medically credible drug, while simultaneously gaining criticism as an intoxicant akin to opium and a major cause of insanity in India.

As a result of the shift in attitudes towards cannabis, the drug was targeted by anti-opium campaigners in London. It was first mentioned in Parliament as part of a broader assault on

²⁴ Andrew Hand et al., “History of Medical Cannabis,” 389; Booth, *Cannabis: A History*, 117-119.

²⁵ Mills, *Cannabis*, 86. Mills details how in many cases, it was the policemen who detained the patient who filled out the paperwork upon which these statistics were based. This paperwork was not considered complete unless a cause of insanity was listed. “This meant that they would have to *make up* a cause of insanity, and in such a situation ‘ganjah-smoking’ was a convenient way of filling the document and one that was likely to be believed” (emphasis added). This connection between drug use, addiction, and insanity was common in the 19th and early 20th centuries and is explored in greater detail in further sections.

²⁶ Ibid., 89.

²⁷ Ibid., 86.

opium in the summer of 1891.²⁸ The adoption of cannabis by British anti-opium advocates points to an important development in the perception of the drug and its users: “the hemp plant and its preparations were not being considered in their own right, but were instead being lumped together with other narcotics by those that wished to attack all stimulants and narcotics.”²⁹ By the 1890s, temperance reformers had formulated political attitudes towards drugs that were negative enough to blur the distinctions between intoxicants and view them all as sources of immorality and social degeneracy, to the point that another reformer described cannabis as “the most horrible intoxicant the world has yet produced.”³⁰ Political pressure grew regarding both opium and, to a lesser degree, cannabis, until finally the Indian Hemp Drugs Commission (IHDC) was established in 1893, with the purpose of investigating the cultivation and trade of cannabis drugs, the effect of their consumption upon the “social and moral condition” of the people, and the desirability of prohibition.³¹ This concession surprised the anti-opium bloc, but it was likely a ploy used by the Under-Secretary of State for India to defuse the anti-opium bloc’s efforts to force government action regarding the more lucrative, and more problematic, opium trade.³² Regardless of the political nature of its origins, the Commission commenced in 1894.

The IHDC report was a truly impressive sociological study, which included both colonial officials and non-official Indians in the ranks of its surveyors, and remains “to the present day the most thorough official study of cannabis ever conducted.”³³ Over 3500 pages in length, it

²⁸ British Parliament, *Hansard’s Parliamentary Debates*, 355 (3rd Series), 16 July 1891, 1395-1412, quoted in Mills, *Cannabis*, 94.

²⁹ Mills, *Cannabis*, 94.

³⁰ W.S. Caine, *Picturesque India: A Handbook for European Travelers* (London: Routledge, 1890), 292, quoted in Mills, *Cannabis*, 98.

³¹ Mills, *Cannabis*, 100.

³² Ibid., 102.

³³ Booth, *Cannabis: A History*, 140.

surveyed the economic, social, cultural, criminal, and public health aspects of cannabis use in India, including an extensive review of the statistics produced by the insane asylums. The report came to a number of startling conclusions. Cannabis was used extensively throughout India, both religiously and recreationally, but use was not increasing. The moderate use of cannabis was not a cause of physical harm or insanity. Of users, only 5% were estimated to be using excessively, despite its widespread availability. There were few social consequences for a population indulging moderately, it was extremely unlikely to induce criminal behavior, and even excessive users were “hardly likely to threaten public order except in the rarest of circumstances.” Because of these conclusions, the IHDC could not recommend prohibition and recognized that the wild growth of cannabis would render such a measure almost pointless.³⁴ It is important to remember that the IHDC was introduced because of its political utility in obfuscating debates on the issue of opium, but the sheer volume of evidence it produced gives some credence to its conclusions.

The report’s monumental rejection of the temperance reformer position fell on deaf ears, however. The results of a similar Opium Commission had been published shortly before, and its conclusions dominated parliamentary debates and split the ranks of the anti-opium advocates. If anything, this highlights the lack of genuine interest in cannabis, beyond its utility as a political tool in both the hands of temperance reformers and colonial officials in the debates over opium. The history of cannabis in India during the 19th century also produces a rather troubling revelation, however: despite the host of literature, often published by representatives of the imperial government or well-respected medical journals, *none* of these sources were referred to in the Canadian prohibition of cannabis almost thirty years later. Not a single reference to

³⁴ Mills, *Cannabis*, 118-121.

cannabis, let alone the literature on it (either positive or negative), can be found in the Sessional Papers, Department of Health reports and records, or House of Commons debates prior to its criminalization in 1923. This certainly makes the mystery of criminalization all the more perplexing, in that Canadian officials had such a large body of knowledge to draw upon yet failed to do so. The history of cannabis in India presented fertile grounds for debate, yet none occurred. It also raises an important question: if no one in Canada was using cannabis, and if members of parliament were so uninterested that they failed to even debate criminalization, then why was it criminalized at all?

Medical Authority and the Development of Addiction

Over the course of the 19th century, the Western medical community was in the process of professionalizing. It is quite possible that Canadian doctors would have read the work of O'Shaughnessy and others in international medical journals, such as *The Lancet*, as they were attentively observing, if not actively participating in, the broader international dialogue regarding the use of certain drugs and their relationship to the social authority of physicians.³⁵ As the 19th century progressed, it became increasingly clear to both physicians and pharmacists in Canada that unrestricted public access to potentially dangerous drugs was problematic. Health professionals argued that such drugs were a risk to national health, with the implication that their medico-scientific expertise qualified them to exclusively regulate the distribution and administration of dangerous drugs. In order for medical professionals to be taken seriously as social authorities by the developing Canadian nation, they needed to regulate dangerous drugs, as well as develop an understanding of addiction. In the process of legitimizing their authority to protect the health of the nation, the medical community problematized addiction and drugs in a

³⁵ Dan Malleck, *When Good Drugs Go Bad: Opium, Medicine, and the Origins of Canada's Drug Laws* (Vancouver: University of British Columbia Press, 2015), 29.

manner that both conflated different types of intoxicants and enabled them to be understood as a public problem that could be addressed through restrictive legislation.

In the 1870s, cannabis and other drugs were included in some of the first provincial pharmacy acts in Canada. Prior to the legislation, drugs, including extremely hazardous drugs such as strychnine, arsenic, and opium, were bought and sold in what was essentially a free-market economy.³⁶ The pharmacy acts officially established professional pharmacy colleges, and reserved the right to distribute items on the “poison schedule” for physicians and pharmacists.³⁷ By controlling such substances, doctors and pharmacists hoped to reduce cases of accidental poisoning, as well as prevent members of the public from developing addictions.³⁸ This was only the first step, however. After the passage of the pharmacy acts, both doctors and pharmacists increasingly began to target patent medicines as the new, unregulated public health threat. These concerns culminated in the 1908 Patent and Proprietary Medicines Act and the Opium Act, which illustrated the new willingness of both the public and the state to accept the authority of medical science in regulating public health issues.³⁹ In passing such laws, which exempted doctors from the restrictions, the role of medical professionals was established as the protectors of national health against the threat of drugs. While the initial pharmacy laws were founded based upon the idea that certain drugs were dangerous poisons, and hence required restriction, by 1908 the professional medical community had managed to “gradually expand the definition of dangerous drugs and to entrench the importance of controlling these substances.”⁴⁰

³⁶ Dan Malleck, “Pure Drugs and Professional Druggists: Food and Drug Laws in Canada, 1870s-1908,” *Pharmacy in History* 48, no. 3 (2006): 104.

³⁷ Malleck, *When Good Drugs Go Bad*, 55.

³⁸ Malleck, “Pure Drugs and Professional Druggists,” 104.

³⁹ *Ibid.*, 113.

⁴⁰ Malleck, “*When Good Drugs Go Bad*,” 248.

Specifically, the definition of the problem of dangerous drugs was inflated to incorporate the emerging idea of addiction.

Addiction to opiates was problematized on two distinct levels by the medical community during the 19th century: the personal and the public. The former was conceptually located in the ideas regarding the causes of addiction. In the early years of the 1800s, the “opium habit” was publicly known, but it had been primarily presented as an issue of morality and the soul. This was largely due to the existing medical theory of humoralism, specifically the principle of “humoral individualism.” It was generally understood by doctors that “everyone possessed their own peculiar and innate crasis, [and] it was acknowledged that one drug or remedy might suit some but harm others.”⁴¹ Under these terms, addiction was understood to be a “weakness of the will,” and part of a broader constellation of immoral behaviors, such as sexual promiscuity, gambling, and heavy drinking.⁴² What characterized these conceptions of addiction was the location of causation in a flawed person or soul, and a lack of differentiation between addiction to intoxicating substances and other behaviours that were considered immoral. As the century progressed, however, iatrogenic addiction became a public health issue and a threat to medical authority, as opiates were increasingly used and prescribed. Opium imports peaked in the 1890s, and medical professionals were the primary source of these drugs.⁴³ After many addictive drugs fell under their exclusive purview due to the pharmacy acts of the 1870s, doctors and pharmacists acquired a new degree of responsibility for the negative effects of the drugs within

⁴¹ Louise Foxcroft, *The Making of Addiction: The ‘Use and Abuse’ of Opium in Nineteenth-Century Britain* (Hampshire, England: Ashgate Pub., 2007), 82. Alternatively, Malleck suggests that missionaries working with opium addicts in China developed the moralistic foundation of addiction. Regardless, it is clear that in the early 19th century, addiction was viewed as a problem that resulted from the nature of the individual. Malleck, *When Good Drugs Go Bad*, 90.

⁴² Malleck, *When Good Drugs Go Bad*, 114-115.

⁴³ Ibid., 13-28.

that legislation. With that responsibility came the potential to be considered complicit in the addiction problem.

At the time of the passing of the provincial pharmacy acts, the existing definition of addiction offered little in terms of opportunities for medical intervention. However, by mid-century the medical community had grown sufficiently concerned about iatrogenic addiction to refine their ideas regarding addiction. As a result, doctors redefined addiction in a manner that paralleled developing conceptions of insanity, by emphasizing the loss of the addict's ability to exert their will.⁴⁴ Most importantly, "the concept of the will in medical theory bridged the gap between the physiological and the psychological," allowing doctors to connect the physical structures of the addicted body to the loss of agency and morality for the addicted mind.⁴⁵ This was done without fundamentally altering several key aspects of the logic that was characteristic of the early humoural definitions, and resulted in an "eminently powerful combination of pathology and morality."⁴⁶ Consider this description of opiate addiction from a medical text that was published in 1893: addiction was "a central neurotic change, brought about by *the long persisting perversion of function and impairment of central nervous nutrition*, from its persisting presence in the nutrient pabulum of the circulation."⁴⁷ If the reader is confused by the terminology, that is because it is essentially hollow; such definitions offered little as a meaningful understanding of addiction, but they did relocate it from the soul to the body, while retaining the belief that addiction was "more deeply informed by the perceived character of the patient than the perceived character of his or her putative disease," such that addiction was

⁴⁴ Foxcroft, *The Making of Addiction*, 123.

⁴⁵ Ibid.

⁴⁶ Ibid., 140.

⁴⁷ Malleck, *When Good Drugs Go Bad*, 119. Emphasis in quote added.

viewed “as atavism not affliction.”⁴⁸ These definitions allowed for the “moral insanity” of addiction to be treated as a “hybrid disease, a physiological affliction with behavioural symptoms.”⁴⁹ By emphasizing the importance of the will of the addict in understanding addiction, responsibility for addiction was relocated from doctors prescribing addictive drugs to individuals incapable of summoning the willpower to take them correctly.⁵⁰ This helped to insulate the medical profession from criticism, but it also transformed addiction into a public health crisis.

As the medical community theorized regarding the somatic source of addiction in individuals, they also shaped the manner in which addiction and addicts themselves were understood as a threat to the public. Addiction was increasingly conceptualized as a disease, as a result of “the medical identification and elaboration of perceived dangers that were social, political, and economic, as well as physiological and psychological.”⁵¹ The concept of the lost will of the addict was viewed as a loss of self-control and personal sovereignty, rendering the addict enslaved “to the substance as much as to the animal cravings.”⁵² Often, the symptoms of the addict were gendered as well, leading to weakness, feebleness, emaciation, and sterility in men, while women risked both sterility and severe mental and physical birth defects in infants.⁵³ These symptoms of addiction-as-disease clearly threatened 19th century ideals in a number of manners; the loss of self-control to wild, animalistic desires, the decay of ideal masculine traits, and the inability to raise healthy children were all poignant, particularly in an era and nation

⁴⁸ Darin Weinberg, “Post-Humanism, Addiction, and the Loss of Self-Control: Reflections on the Missing Core in Addiction Science,” *International Journal of Drug Policy* 24, no. 3 (May 2013): 174.

⁴⁹ Foxcroft, *The Making of Addiction*, 119.

⁵⁰ Ibid., 126.

⁵¹ Ibid., 80.

⁵² Dan Malleck, “‘Its Baneful Influences Are Too Well Known’: Debates over Drug Use in Canada, 1867-1908,” *Canadian Bulletin of Medical History* 14, no. 2 (1997): 267.

⁵³ Ibid., 268.

where population growth was federal policy.⁵⁴ The normative effects emerging from physical deficiencies allowed for the “symbolic embellishment and metaphorical analogies of the corruption and pollution of society, as well as the individual.”⁵⁵ Having constructed addiction as a problem with physical causes on the personal level and moral effects on the public, national level, medical professionals were able to imbue themselves with the authority to “ensure the liberty and integrity of the nation.”⁵⁶ Addiction was thus defined as a threat to Canadian public health and national integrity, which would later allow the moral reform movement to incorporate drug addiction in anti-oriental narratives.

This emphasis on physical predispositions with normative effects also resulted in the obfuscation and lack of differentiation between narcotic substances. In any drug, “notwithstanding its actual physical effects, lay [the] potential danger” of addiction for the predisposed body.⁵⁷ While these views were still developing in the latter half of the 19th century, they would “ultimately lead to the idea that a much wider range of drugs should be limited by legislation.”⁵⁸ In fact, a number of substances that we believe are harmless today were defined as “narcotic” alongside far more dangerous drugs; for example, one medical text from the 1860s gave opium and coffee parity as narcotics.⁵⁹ As a result, it was not “the particular substance

⁵⁴ Ibid., 269. Malleck also notes that the image of “an enslaved respectable woman, who in Victorian cosmology was the keeper of social morality through her governance of the home, would have been particularly shocking.”

⁵⁵ F.E. Anstie, *Stimulants and Narcotics: Their Mutual Relations* (London, 1864) 1-20, quoted in Foxcroft, *The Making of Addiction*, 168.

⁵⁶ Malleck, “Debates over Drug Use in Canada,” 274.

⁵⁷ Malleck, *When Good Drugs Go Bad*, 120.

⁵⁸Ibid.

⁵⁹ Foxcroft, *The Making of Addiction*, 143. This point raises the question of what exactly a narcotic is, and whether or not cannabis is one. In Richard Davenport-Hines text *The Pursuit of Oblivion*, he defines narcotics as drugs that “relieve pain, induce euphoria and create physical dependency. The most prominent are opium, morphine, heroin and codeine.” Alternatively, he categorizes cannabis as one of the hallucinogens, which “cause complex changes in visual, auditory and other perceptions and possibly acute psychotic disturbance.” However, some of the most compelling arguments for the decriminalization for cannabis rest upon its therapeutic value as an alternative to narcotics, which

which [carried] damaging potential but the individual who [responded] idiosyncratically... according to his or her temperament.”⁶⁰ Cocaine, morphine, and opium dominated the debates regarding drugs, but by the early 20th century these drugs were being viewed as “similarly problematic substances, notwithstanding their unique biological properties [and] uncertain physical and psychological effects.”⁶¹ Although the lack of differentiation between drugs that resulted from medical conceptions of addiction was largely established in the 19th century literature of the medical community, this effect can be clearly seen in the work of later moral reformer movement texts in during the drug panic of the 1920s as well. While cannabis was rarely explicitly mentioned by moral reformers, it can be easily understood how these conceptions of addiction would have resulted in the inclusion of cannabis in the category of “dangerous drugs.”

The medical construction of addiction would not have proven so vital had addiction remained an issue isolated in the debates of medical professionals. However, by 1908, doctors had sufficiently convinced both the public and its representatives that addiction was a problem best managed through restrictive legislation that further protected the right of medical professionals to prescribe and distribute dangerous drugs. While many scholars have identified William Lyon Mackenzie King’s 1908 report on opium as the source of Canada’s first criminal drug legislation (in the form of the 1908 Opium Act), it is quite clear that the report was built

suggests that cannabis has at least some narcotic properties (particularly regarding pain relief). Regardless, it seems plausible that, if the 19th century definition of narcotic was loose enough to include caffeine, it would have included cannabis as well. Richard Davenport-Hines, *The Pursuit of Oblivion: A Global History of Narcotics, 1500-2000* (UK, London: Weidenfeld & Nicolson, 2001), ix-x; for more information on the contemporary debates regarding the therapeutic value of cannabis, there is a large body of literature, but a good place to start is Zach Walsh et al., “Cannabis for therapeutic uses: Patient characteristics, access, and reasons for use,” *Drug Policy* 24, no. 6 (November 2013): 511-516.

⁶⁰ Foxcroft, *The Making of Addiction*, 143.

⁶¹ Malleck, *When Good Drugs Go Bad*, 239.

upon the constructions of addiction and opium use that had been present in Canadian culture for quite some time. One obvious example is his famous claim in the report that opium's "baneful influences are too well known to require comment," but King also referred to the existing pharmacy legislation as legal precedent.⁶² Not only was parliament highly cognizant of the threat that opium posed to public health and morality, but it was also unanimous in criminalizing the substance.⁶³ Newspapers were similarly supportive of the legislation, except to comment that it could not have come sooner.⁶⁴ What neither the newspapers nor parliament recognized, however, was that the law had created a criminal class of recreational users, and thus generated the demand for even harsher regulations.⁶⁵ This demand was satiated by the stricter 1911 Opium and Drug Act, "which combined the criminalization framework erected in the 1908 Opium Act with the broader social concerns" regarding other popularly used drugs, such as cocaine and morphine.⁶⁶ Drug use had become a social problem that generated demand for restrictive legislation, with a marked lack of discrimination regarding the nature of the drugs themselves. Moreover, by constructing drug addiction as a threat to the moral and physical integrity of the nation, the medical community enabled the moral reform movement to draw parallels between medical conceptions of addiction and the threat posed by Chinese immigrants.

⁶² Canada, Department of Labour, *Report of W.L. Mackenzie King, C.M.G. Deputy Minister of Labour: Losses Sustained by the Chinese Population of Vancouver, B.C.*, 1908, 15; Malleck, *When Good Drugs Go Bad*, 226.

⁶³ Malleck, *When Good Drugs Go Bad*, 227. According to Malleck, the leader of the opposition at the time, Robert Borden, joked about parliament's unanimity. Apparently, a member of parliament that he knew had been upset, because he had prepared a speech in favour of the legislation that he was unable to deliver because parliament approved it before he could.

⁶⁴ Ibid., 231.

⁶⁵ Ibid.

⁶⁶ Ibid., 233.

The 1920s Drug Panic: Moral Reformers and Legislators

Members of the medical community were instrumental in problematizing addiction and pushed hard for exclusive rights that were enshrined in legislation, but their demands were a far cry from the criminalization legislation that was passed between 1908 and 1923. The criminalization of various drugs, including cannabis, was the result of a moral reform movement that targeted the social problem of addiction that doctors had created. The middle class was instrumental in shaping the agenda of the moral reform movement, by organizing itself and pushing for state intervention in “regulating morality.”⁶⁷ These groups could represent a variety of interests and people, ranging from Christian church congregations, to labour organizations, to nationalists, or the Women’s Christian Temperance Union. Generally, the moral reformers were pushing for their vision of a Christian nation, but as can be seen from the groups listed above, these visions were diverse. At times, however, they could unite in addressing contemporary issues, causing an “umbrella effect.”⁶⁸ This “umbrella effect” refers to the phenomena of apparently diverse and even ideologically opposed groups finding common ground in pushing for specific pieces of legislation, such as when labour leaders and temperance advocates unified in their calls to restrict oriental immigration. The problem of drugs and their users generated one such umbrella effect, because drug addiction was successfully constructed as a threat to the self-control of people who used drugs. The evidence for this can be seen in the sensationalized narratives that filled contemporary newspapers and magazines, which demonstrate how Canadians viewed the “drug problem.” The efforts of the moral reform movement were

⁶⁷ Marcel Martel, *Canada the Good: A Short History of Vice Since 1500*, (Waterloo, Ontario: Wilfred Laurier University Press, 2014), 4.

⁶⁸ Ibid.

enormously successful, and by the 1920s its influence is clearly visible in the House of Commons debates and personal memoirs of members of parliament.

The policies of the moral reform movement were built upon the values of inner discipline and self-regulation in maintaining social order and improving society general. This middle-class belief that “the locus of social control” rested upon the individual dictated that self-regulation is necessary in order for individuals to survive and succeed in society.⁶⁹ In other words, “to govern the population required the government of individuals within it... The absence of ‘will’... would render the population ungovernable within the parameters of liberalism.”⁷⁰ Because addiction had been defined as a physical disease resulting in the loss of one’s will, it presented a fundamental threat to these ideals of personal sovereignty. “Addiction was interpreted by people in light of their struggles with their own desires,” so many reformers believed that addiction was “the source of most social problems.”⁷¹ It was an idea used to describe “a mystery: the mystery of the drinker or drug user continuing to use despite what is seen as the harm... resulting from use.”⁷² Under these terms, the moral reformer solution for drug addiction was relatively simple, and mirrored their arguments regarding the prohibition of alcohol: remove the cause of the loss of self-control (drugs) to promote self-control, and hence improve society as a whole.

The appetite for reform developed due to the forces of industrialization and urbanization over the course of the 19th century. Canadian confederation was built upon the federal promise

⁶⁹ Harry Levine, “The Discovery of Addiction: Changing Conceptions of Habitual Drunkenness in America,” *Substance Abuse Treatment* 2, no. 1 (1985): 52.

⁷⁰ Toby Seddon, *A History of Drugs: Drugs and freedom in the liberal age* (New York: Routledge Press, 2010), 23.

⁷¹ Harry Levine, “The Discovery of Addiction,” 53.

⁷² Robin Room, “The culture framing of addiction,” *Janus head* 6, no. 2 (2003): 225. Room emphasizes that in many ways, these concepts still hold “vitality” today, in that our ideas about addiction still rest upon “the criterion that is at the heart of addiction concepts: the loss of control, or, in recent formulations, impairment of control.”

to improve the infrastructure between trade centers, and by the 1870s, the growth of Canadian industry and manufacturing was a fundamental part of the Canadian federal government's National Policy. Under these conditions, urban areas were more easily accessible and offered labour opportunities for poorer people. The shifts in economic relations generated social turmoil and brought increasing numbers of working-class people within close proximity to, and under the scrutiny of, civil society and the middle class.⁷³ As a reaction to "social and economic forces that profoundly challenged their beliefs, Christians from various denominations launched an offensive that became more sophisticated, refined, and determined over the years."⁷⁴ The work of moral reformers would prove important in passing anti-drug legislation, which "would never have passed through the House of Commons" without the sense of panic and pressure that their campaign evoked in the public.⁷⁵ Their success can be largely attributed to the successful creation of an association between drug use and Asian immigrants, by presenting these immigrants as people who used, and spread the use of, drugs in Canadian society, and who lacked the values championed by moral reformers.

At the turn of the 20th century in Canada, anti-Asian sentiments in immigration policy discourses were constructed upon the racist concept that specific populations lacked sexual and moral self-control and were therefore inassimilable and posed the risk of miscegenation. As discussed before, moral reformers viewed morality, and hence civilization, as the denial of instinctual desires and the strict regulation of behaviour, and many viewed these qualities as inherent to specific races.⁷⁶ Because of the supposed differences in "habits, morals, customs, and

⁷³ Martel, *Canada the Good*, 50.

⁷⁴ Ibid.

⁷⁵ Catherine Carstairs, "Deporting 'Ah Sin' to Save the White Race," 67.

⁷⁶ Mariana Valverde, "Racial Purity, Sexual Purity, and Immigration Policy," in *The History of Immigration and Racism in Canada: Essential Readings*, ed. Barrington Walker (Toronto: Canadian Scholar's Press, 2008), 175.

standards of living” between Asian immigrants and Occidental settlers, “White Canadians generally believed that Asians were inassimilable.”⁷⁷ According to reformers, the nation was composed of the racially classified bodies of individuals, and the proportions of different races determined the nature of the nation’s moral and sexual purity. This meant that the racial composition of the population required careful regulation, to avoid the risk posed by racially inferior bodies incapable of self-control.⁷⁸ Inassimilability was often accompanied by theories regarding the “supposed evil of miscegenation,” which was the belief that racial mixing would lead to the degeneration of the White Canadian race.⁷⁹ It was often argued that the offspring of racial intermarriage would exhibit the inherent vices of both the races, to the detriment of virtuous qualities.⁸⁰ These themes would be drawn upon heavily in the drug panic of the 1920s, and would incorporate drugs to legitimize the threat posed by Orientals. Many reform movements were at least tangentially concerned with drugs, but “more than any other cause, anti-Asian racism fuelled the drug campaign.”⁸¹ Asian immigrants were regularly associated with immoral behaviours, and stories often emphasized the role of drugs as a vector for “infecting” civil society with vice.⁸²

⁷⁷ Patricia Roy, *The Oriental Question: Consolidating a White Man’s Province, 1914-41* (Vancouver: UBC Press, 2003), 26.

⁷⁸ Valverde, “Immigration Policy,” 176.

⁷⁹ Roy, *The Oriental Question*, 32.

⁸⁰ Ibid., 33.

⁸¹ Catherine Carstairs, “Innocent Addicts, Dope Fiends, and Nefarious Traffickers: Illegal Drug Use in 1920s English Canada,” *Canadian Studies* 33, no. 3 (1998): 148.

⁸² Canada was not alone in linking Asian immigrants to addiction. According to Timothy Hickman, this sentiment was highly visible in American culture as well. Keeley, the famous cure-doctor of the late 19th century, “located the Oriental threat of addiction closer to home by inscribing it upon the bodies of the Oriental immigrant population.” Anti-orientalism was transnational in many respects. Timothy Hickman, “Drugs and Race in American Culture: Orientalism in the Turn-of-the-Century Discourse of Narcotic Addiction,” *American Studies* 41, no. 1 (Spring 2000): 75.

The moral reform movement and major media outlets generated a drug use crisis in the 1920s.⁸³ “Drug scares are a form of moral panic ideologically constructed as indicative of a wider social malaise,” and in the 1920s, this “malaise” was Asian immigration and immoral behaviour due to the loss of self-control that drug addiction caused.⁸⁴ The first major story that captured public attention was the case of Joseph Kehoe in 1921. Kehoe was a returned hero from the First World War, who had turned to crime in order to support his drug habit. He exemplified the moral degradation that resulted from drug use, but both Kehoe and the media came to blame “dope peddlers,” rather than users.⁸⁵ Shortly after Kehoe’s story was published, the *Vancouver Sun* published another story about a wealthy Chinese immigrant who “boasted that he was turning over more than half a million dollars’ worth of drugs each year,” which helped establish the stereotype of Chinese drug dealing.⁸⁶ However, it was not until early 1922 that Vancouver newspapers, particularly the *Vancouver Daily World*, really began to push the relationship between Asian immigrants and drugs: “from the day the *World* campaign began, it was clear that they blamed Asians for the spread of the drug habit... The idea that the Chinese were consummate drug smugglers, on account of their ingenuity and cleverness, would not come

⁸³ Carstairs, “Innocent Addicts, Dope Fiends, and Nefarious Traffickers,” 145; Carstairs, *Jailed for Possession*, 36; David Courtwright, *Dark Paradise* (Cambridge, MA: Harvard University Press, 1982), 34. There are some difficulties in determining the actual rates of drug use in Canada. Carstairs describes the narratives of drug use as an “imaginary world,” in her article titled “Innocent Addicts, Dope Fiends, and Nefarious Traffickers,” but fails to elaborate on how common drug use actually was. In her book, *Jailed for Possession*, she similarly describes the threat as “exaggerated,” but goes on to recognize that there was a “significant increase in drug use in the 1910s.” In Courtwright’s *Dark Paradise*, which is admittedly concerned with American rates of drug use specifically, he argues the “objective evidence indicates that, far from increasing during the early twentieth century, the rate of addiction declined steadily from 1900 to 1914.” I am inclined to believe that regardless of whether rates were increasing or decreasing, Carstairs is correct in stating that the drug narratives were exaggerations of the reality of drug use in society.

⁸⁴ Ross Coomber, Karen McElrath, Fiona Measham and Karenza Moore, *Key Concepts in Drugs and Society* (London: SAGE, 2013), 158.

⁸⁵ Carstairs, “Deporting ‘Ah Sin’ to Save the White Race,” 73.

⁸⁶ *Ibid.*, 74.

as any surprise to the citizens of Vancouver.”⁸⁷ The newspapers were echoed by various moral reform groups, such as the Child Welfare Society, Evangelist leaders, the Rotary and Kiwanis clubs in developing a narrative of “white victims and Chinese villains.”⁸⁸ One of the major authors in this movement was Emily Murphy.

Emily Murphy’s 1922 book, *The Black Candle: Canada’s First Book on Drug Abuse*, while odious and disorganized, is valuable in that it is a contemporary attempt to survey various drugs and the manner in which they threatened society. Carstairs argues that Murphy had little influence on the government officials concerned with narcotic control, but she does recognize that Murphy “brought the Vancouver drug panic to a larger Canadian audience.”⁸⁹ As such, her work is useful in examining the popular representations of drugs and their users in Canada. The narratives of drug use were populated with stereotypical characters that traced the devolution of the “innocent addict” to the “dope fiend,” a process that was orchestrated by the racially inferior traffickers. Young white people, often children and often female, were most commonly presented as potential addicts, as they “represented innocence under threat.”⁹⁰ In *The Black Candle*, Murphy emphasizes the innocence, vulnerability, and wasted potential of the child addict. She describes the distribution of drugs as candies to school children in New York, as well as the tale of a student who sold his impoverished mother’s property for drugs: “This young man is a university graduate, but his craving for drug content, born at a cabaret party, had reduced his mother to penury and himself to a moral and physical wreck.”⁹¹ These narratives emphasized the predatory nature of drug dealers, and the disruptive and destructive effect that

⁸⁷ Ibid., 76.

⁸⁸ Ibid., 77.

⁸⁹ Ibid., 71.

⁹⁰ Carstairs, “Innocent Addicts, Dope Fiends, and Nefarious Traffickers,” 149.

⁹¹ Emily Murphy, *The Black Candle: Canada’s First Book on Drug Abuse*, (Toronto: Thomas Allen, 1922): 126-127.

drug addiction had in upstanding Canadian homes, largely through a loss of self-control. The second archetype in drug narratives was the dope fiend.

The dope fiend was typically constructed as the mature, morally malformed result of an addiction, who often explicitly violated the gender roles and moral tenets of the day; the dope fiend was envisioned as the diseased tissue in the national body and was the vector for spreading drugs and immorality in the population. Murphy tells the story of a girl who “boasted that she gets \$25.00 commission for every boy and girl she initiated into the drug habit” in order to emphasize the lack of remorse and potential incentives for those who spread drug addiction.⁹² Murphy also connected mature addicts to the literal mixing of racially different bodies and miscegenation:

A man or a woman who becomes an addict seeks the company of those who use the drug... this explains the amazing phenomenon of an educated gentlewoman... consorting with the lowest classes of yellow and black men.... Under the influence of the drug, the woman loses control of herself; her moral senses are blunted, and she becomes ‘a victim’ in more senses than one.⁹³

The multiple senses of victimhood obviously connote interracial sexual relations, and hence miscegenation. This was an important contemporary symbol for social decline, moral degeneration, and lost respectability, and drug use was identified as the means by which supposedly racially inferior groups were enticing white women to procreate with them.⁹⁴ Under these terms, drug addiction and oriental immigrants were linked through miscegenation as threats to the moral and racial integrity of the White Canadian population.

Evidently, moral reformers problematized drug use and Asian immigration as a unified moral and physical issue, both on the personal and national level, but they did so in a manner that

⁹² Ibid., 128.

⁹³ Ibid., 17.

⁹⁴ Carstairs, “Innocent Addicts, Dope Fiends, and Nefarious Traffickers,” 151.

obscured the differences between drugs. This was a reproduction of the lack of differentiation between intoxicants that was present in the medical community's conceptions of addiction, but it also magnified the negative impact of drug use upon the morality of the addict. As a result, "pro-control advocates generally assumed drugs engendered universal effects, regardless of circumstances."⁹⁵ In *The Black Candle*, Murphy emphasizes that "in whatever form these drugs are taken, they degrade the morals and enfeeble the will. No matter what their status has been, inveterate users of drugs become degraded."⁹⁶ Similarly, she describes the negative impact of cocaine use at parties in a manner that obfuscated the symptomatic differences of drugs, and instead emphasized the moral degeneration that they all resulted in: "The effects of these orgies on the participants are various, but always deplorable, making for perverted senses and the enfeeblement of the will. *Cocaine ultimately vitiates all the relations of life.*"⁹⁷ Clearly, Murphy illustrates how "physical effects were not as significant to many writers as the moral impact of cocaine addiction;" namely, the loss of self-control, and her work is exemplary of "the tendency of the time to believe the worst of drugs on scant evidence."⁹⁸ She was predictably hostile towards the drugs commonly problematized by the moral reform movement, but she also wrote on cannabis, despite its obscure status in moral reformer discourses.

Her chapter on cannabis depicts similar, if not worse, effects of use: "Addicts to this drug, while under its influence, are immune to pain... and are liable to kill or indulge in any form of violence to other persons... without, as said before, an sense of moral responsibility."⁹⁹ While

⁹⁵ William B. McAllister, *Drug Diplomacy in the Twentieth Century: an International History* (New York: Routledge, 2000), 21. McAllister also points out that this was a vital part of recruiting the temperance movement: "in their fight against inebriety, temperance workers perceived little difference between 'dangerous drugs' and alcohol."

⁹⁶ Murphy, *The Black Candle*, 42.

⁹⁷ Ibid., 221. Emphasis added.

⁹⁸ Malleck, *When Good Drugs Go Bad*, 190; Giffen et al., *Panic and Indifference*, 153.

⁹⁹ Murphy, *The Black Candle*, 333.

this is absurd to the modern reader, it would have served as a solemn indicator to contemporary readers of the threat that drug use posed to Canadian society. Interestingly, Murphy references the work of “eminent medical doctors in India,” so she was likely aware of the fact that cannabis was commonly used in the Middle East and India, as well as studied by British doctors there. She was selective in her research, however, as she does not refer to the IHDC, or the favourable conclusions of O’Shaughnessy and other British doctors who supported cannabis. Murphy explicitly links cannabis to its Oriental origins when she notes, “it is also a peculiarity of hasheesh [sic] that its fantasia almost invariably takes the Oriental form,” as well as that “it is believed that the *Arabian Nights* were written under the motor excitement of hasheesh. The romancer under its influence travelled on a magic carpet and saw strange lands and sights.”¹⁰⁰ She viewed cannabis as a degrading substance similar to the drugs more commonly attacked by moral reformers, and particularly threatening due to the associations that it had with Asian societies. Murphy’s work demonstrates how the emphasis those moral reformers placed upon the potential racial and moral implications of drug use and drug addiction resulted in a highly problematic conception of drugs themselves, in that the normative effects that their use supposedly caused obfuscated the differences between drugs as addictive substances.

The rhetoric of moral reformers is particularly important, because it so obviously shaped Canadian drug policy in the 1920s. For example, in explaining why a relatively high proportion of convictions for drug trafficking occurred in coastal British Columbia in 1922, Henri Béland, the Minister of Health, said “the large number of convictions... would... naturally result from the geographic situation of that province. I presume that there is a larger number of Chinamen in Vancouver and Victoria... and the proximity of these places to the Orient would perhaps account

¹⁰⁰ Ibid., 335.

for the greater extent.”¹⁰¹ A month later, in response to the predominance of convicted Asian immigrants, Archibald Carmichael asked that “all Orientals found trafficking in drugs... be deported.”¹⁰² One of his fellow MPs, Leon J. Ladner, went on to explicitly reproduce moral reformer stereotypes when, in arguing for the lash as a penalty, he asserted that:

the addict must be treated as a patient. The trafficker, generally an Oriental, a cool calculating person... ingeniously inveigles innocent people into the habit... surely a man or woman, white, brown, or yellow, who deliberately induces young girls to become addicts is guilty of a more serious crime against society.¹⁰³

Ladner’s statements were heartily endorsed both by other members as well as the Minister of Health. The parliamentary debates that accompanied restrictive legislation in the early 20th century indicate the “pervasiveness of beliefs favourable to the growth of the drug mythology.”¹⁰⁴ They were defined by the racial prejudices and potential moral impacts of drug use, rather than a nuanced discussion of the drugs themselves. Parliamentarians, like moral reformers, simply were not interested in contradictory evidence.

Revisiting the Mystery: Testing the International Theory

Cannabis was criminalized without fanfare; it wasn’t even referred to specifically in the House of Commons. Henri Béland, the aforementioned Minister of Health who introduced the legislation, simply announced that “there is a new drug in the schedule” before the bill was read for a third time and passed.¹⁰⁵ Considering the content of Murphy’s writing on cannabis, it is no surprise that it has since been blamed by many for criminalization. However, as mentioned before, Carstairs questions the role of the chapter in causing criminalization: “this was the twenty-third chapter in a 400-page book. It was only seven pages long and garnered no

¹⁰¹ House of Commons, *Debates* (hereafter HCD), 19 May 1922, 2018.

¹⁰² Ibid., 2824.

¹⁰³ Ibid., 2825.

¹⁰⁴ Giffen et al., *Panic and Indifference*, 150.

¹⁰⁵ HCD, 23 April 1923, 2124.

significant attention at the time.”¹⁰⁶ Again, Carstairs also argues that Murphy had little influence in the policy formation process by the time of criminalization, because she was not respected by the officials of the Opium and Narcotic Drugs Branch. This is a critical insight, because it suggests that, at least in the case of cannabis, prohibitive legislation hinged upon the influence of that branch. However, the issue remains highly problematic, as that same branch’s records fail to point to any source for criminalization, Murphy or otherwise.

Carstairs offers an explanation when she suggests that “the real reason probably lies in Canada’s attendance at international meetings where the drug came under discussion.”¹⁰⁷ She specifically points to The Hague Opium Conference of 1911 and 1912 as a potential cause, because it recommended the scientific study of cannabis, and because, according to her, William Lyon Mackenzie King (who was the Prime Minister when cannabis was actually criminalized in 1923) attended the Conference. Carstairs closes the matter by citing another author, Alexander B. Morrison, to support her international theory. Morrison, writing in the 1970s, states that “Col. C. Sharman, then Director of the Federal Division of Narcotic Control, returned from meetings of the League of Nations convinced that cannabis soon would fall under international control. In anticipation of such action, he moved to have it added to the list of drugs controlled under Canadian law.”¹⁰⁸ Alternatively, Giffen suggests that “there is evidence of concern about marijuana in the U.S. for many years before, and this may have been known to the Canadian authorities,” but Carstairs points out that “there is no evidence of direct pressure from the United

¹⁰⁶ Carstairs, *Jailed for Possession*, 31.

¹⁰⁷ Ibid.

¹⁰⁸ Alexander B. Morrison, “Regulatory Control of the Canadian Government over the Manufacturing, Distribution and Prescribing of Psychotropic Drugs,” in *Social Aspects of the Medical Use of Psychotropic Drugs*, ed. Ruth Cooperstock (Toronto: Alcoholism and Drug Addiction Research Foundation of Ontario, 1974), 10.

States.”¹⁰⁹ Most have been willing to subscribe to Carstairs’ international theory, but upon closer scrutiny, it is significantly flawed both factually and logically. The first issue lies in Morrison’s original piece, upon which the “international” position, and the pivotal role of “Col. C. Sharman,” rests. It does not offer a footnote for the claim that Sharman was responsible for the criminalization of cannabis. The paper trail ends with Morrison in 1974, rather than with documentary evidence from either the Canadian government or the League of Nations in 1923. This warrants a closer investigation of the international anti-drug movement, the Opium and Narcotic Drugs Branch, and Colonel Sharman.

The first major gathering was the International Opium Commission, held in 1909 in Shanghai. While the 1909 Commission had no official powers to impose restrictions, and failed to establish even a skeletal agreement on future action, it still introduced drug regulation to the international scene and “publicized the issue.”¹¹⁰ William Lyon Mackenzie King did attend the Commission and spoke on Canadian efforts to restrict opium, due to his involvement in the Vancouver riots in 1907; however, cannabis was not mentioned at all in Shanghai.¹¹¹ Subsequently, the attendees of the Shanghai Commission reconvened at the Hague in December 1911 and January 1912, where cannabis was mentioned, if only briefly. Italian delegates proposed that cannabis be discussed, but apparently neither the Italians themselves nor the other members present were particularly vocal on the subject.¹¹² Representatives from South Africa “pressed for cannabis to be treated as being as addictive as opiates,” but the conference only recommended that the individual member-states conduct further investigations regarding

¹⁰⁹ Giffen et al., *Panic and Indifference*, 180; Carstairs, *Jailed for Possession*, 30.

¹¹⁰ Booth, *Cannabis: a History*, 142; Mills, *Cannabis*, 154. Mills describes the Commission’s resolutions as statements that “involved few commitments and plenty of diplomatic hot air.”

¹¹¹ F.A. McGregor, *The Fall & Rise of Mackenzie King: 1911-1919*, (Toronto: Bryant Press, 1962), 38; Booth, *Cannabis: a History*, 142.

¹¹² Mills, *Cannabis*, 154. The Italians left the Hague before cannabis was ever officially discussed.

cannabis drugs. This still may have been significant, except that none of the states represented at the conference followed through on that recommendation.¹¹³ While cannabis was briefly mentioned at The Hague, it appears not to have been taken very seriously by the officials there.

Even more problematic, it appears that Carstairs' claim that William Lyon Mackenzie King attended the Hague Opium Conference in 1911 and 1912, and so would have witnessed the issues raised by the Italian and South African delegations, is erroneous.¹¹⁴ King's biographers make no mention of his attendance at this Conference, and according to his diaries, he was dining with Wilfrid Laurier, enjoying Christmas with his family, reading to his mother, bustling around Ottawa, and visiting New York during its proceedings.¹¹⁵ While the decade that separates this Conference from the criminalization of cannabis should be more than enough to cast suspicion on its supposed impact, the lack of any significant Canadian representation there only raises further questions about the importance of the event. The international conferences of 1909 and 1911-1912 may have given credence to domestic anti-drug sentiments in a more general sense, but they do not appear to have influenced the specific inclusion of cannabis on the schedule in 1923. On the international drug control agenda, "cannabis products settled back into obscurity for over a decade after 1912."¹¹⁶ The First World War put a halt to any efforts to

¹¹³ Booth, *Cannabis: a History*, 142. Interestingly, South Africa had been struggling to restrict cannabis for some time by the time of the 1911-12 Commission and supported the Italian efforts to include it in the debates. This was largely due to the extensive use of the drug by imported Indian labourers working on plantations and in mines in South Africa. For more information, see Chris Duval's detailed discussion of the situation in South Africa in his book, *Cannabis*.

¹¹⁴ Carstairs, *Jailed for Possession*, 31. I suspect that Carstairs confused the Shanghai Opium Convention with the Hague Opium Conference when she claimed that King attended the latter.

¹¹⁵ Robert M. Dawson, *William Lyon Mackenzie King 1874-1923: A Political Biography* (Toronto: University of Toronto Press, 2014): 225-248; LAC, Diaries of William Lyon Mackenzie King, item numbers 4772 – 4851, 1 December 1911 – 21 January 1912. Interestingly, King's digitized diaries show no record from January 21 to February 5, 1912. The Hague Conference was signed on January 24, and King's entry on January 21 locates him in New York.

¹¹⁶ Mills, *Cannabis*, 157.

restrict the international drug trade, but its immediate aftermath saw restrictive measures reintroduced to the post-war agenda.

After the First World War, the Paris Peace Conference included articles that ratified the Hague Opium Conference of 1912, and subsequently drug restriction fell under the purview of the League of Nations.¹¹⁷ The Advisory Committee on Traffic in Opium and Other Dangerous Drugs first met in May 1921, but was absorbed by debates between the United States and the British Empire regarding the responsibility of states producing the popularly vilified drugs of the day: opium, cocaine, and morphine.¹¹⁸ By the time the Advisory Committee had concluded its fifth session in 1923, “much heated debated had been generated... on the key issue of opium production.... Cannabis meanwhile had been altogether forgotten.”¹¹⁹ The Advisory Committee would later devote some attention to cannabis as a result of pressures from South Africa, but the record is devoid of any mention of it prior to 28 November 1923, five months after Béland had scheduled cannabis in Canada in April 1923.¹²⁰ Cannabis was not considered officially by the League of Nations prior to Canada’s criminalization of it.

At this point, the international theory proposed by Carstairs appears seriously compromised, and beyond the reach of the historical record available to me. Considering the fact that the League did not officially consider cannabis, causation falls to the level of informal relations between diplomats. It is still plausible that a Canadian delegate attending League

¹¹⁷ Ibid.

¹¹⁸ Ibid., 158. When the United States acquired the Philippines at the turn of the century, it also inherited an opium-using population there. This spurred the U.S. to lead the international effort to restrict the drug trade and placed them in direct opposition to the interests of the British Empire, which was enjoying the lucrative benefits of exporting opium from India. The conflict of interests between these two states was the dominant narrative of international anti-drug meetings from the Shanghai Commission in 1909 onwards.

¹¹⁹ Ibid., 160.

¹²⁰ Ibid.

functions heard about the dangers of cannabis in an unofficial capacity; after all, Canadians do appear to have been involved in the Advisory Committee on the Traffic in Opium, which had been appointed by the League to oversee narcotic control.¹²¹ Canada “was regularly represented at the annual League Assemblies and at other conferences and meetings sponsored by the League” from 1920 onwards, but there was no permanent position for Canadians until 1925.¹²² A swath of Canadian delegates attended League of Nations meetings, but many of them “had only the briefest and most superficial connection with the work of the League.... Appointments to the Assembly delegations were used for public relations” rather than to inform the domestic political agenda.¹²³ Canadians were at the League of Nations, and even involved in its work on narcotic drugs, but it is incredibly difficult to ascertain in what capacity from the primary and secondary source literature accessible to me. Regardless, it seems clear that there was no official pressure from the League of Nations to criminalize cannabis specifically before Canada had done so independently. This suggests that the Department of Health and the Opium and Narcotic Drugs Branch, from which the legislation originated domestically, requires closer examination.

The Department of Health was very new in the federal bureaucracy of the 1920s. It was only formed in 1919, and only began to administer drug control in 1920, which is when the Opium and Narcotic Drugs Branch within the Department of Health was established as well.¹²⁴ The chain of command began with the Minister of Health, which was Henri Béland from 1922 to

¹²¹ League of Nations, “Traffic in Opium,” *Official Journal* 3, no.3 (March 1922), 291. Here, the Advisory Committee on Traffic in Opium mentions a “Canadian proposal concerning the annual statement of narcotics in stock” in item number five on the agenda. The minutes of these sessions, which are located in Geneva, would offer clarity regarding the role that Canadians played, and how they interacted with other representatives, and whether there was debate regarding cannabis before it was officially discussed by the League.

¹²² Richard Veatch, *Canada and the League of Nations*, (Toronto: University of Toronto Press, 1975), 22.

¹²³ Ibid., 24-25.

¹²⁴ Giffen et al., *Panic and Indifference*, 104.

1925, then the Deputy Minister of Health, then the “Officer in Charge, Opium and Narcotic Drug Branch.”¹²⁵ This branch would later become the Narcotic Division to which Morrison was referring when he claimed that Sharman was responsible for criminalizing cannabis. It had enormous influence over Canadian drug control policy at a time when it was still in a state of flux, and early in its formation process. The key to the power and influence that the Division Chief held was “the central role he came to occupy in a developing communications network.”¹²⁶ The head of narcotic control in the Department of Health received reports from across the country from both the RCMP and a “special council” of lawyers, who were hired by the federal government to prosecute narcotics cases. He then reported to the Deputy Minister and Minister of the Department of Health.¹²⁷ This meant that, formally, the head of the branch served as the sole source of information that was available for the Department of Health regarding narcotic control, and “his superiors, others in the enforcement network, the mass media, and even medical journals tended to accept his word on drug questions as authoritative.”¹²⁸ These insights are key to understanding the specifics of criminalization in two respects. First, they challenge the role of Emily Murphy in criminalizing cannabis, because by 1923, she had lost the respect of the Officer in Charge, F.W. Cowan, and therefore would not have influenced this key position in the bureaucratic hierarchy.¹²⁹ Second, the fact that it was Cowan, not Sharman, who held that role from the establishment of the branch until 1927 directly contradicts Morrison’s claim that Sharman was the head of narcotic control in 1923, when Sharman supposedly added cannabis to the schedule.¹³⁰ What remains unclear is whether Sharman was involved in a lower level of the

¹²⁵ Ibid., 126.

¹²⁶ Ibid., 139.

¹²⁷ Ibid., 126.

¹²⁸ Ibid., 140.

¹²⁹ Carstairs, “Deporting ‘Ah Sin’ to Save the White Race,” 71.

¹³⁰ Giffen et al., *Panic and Indifference*, 126.

Opium and Narcotic Drugs Branch at that time, and still responsible in some sense for criminalization.

Colonel Sharman has a sizeable record (unlike the drug he was supposedly responsible for criminalizing), that spans from 1898 into the 1940s. Sharman joined the North West Mounted Police in 1898 and served until he was discharged in 1903 as a sergeant. Afterwards, he worked in the Department of Agriculture and joined the artillery branch of the Military in 1906. He served as an artillery officer throughout the First World War, both on the frontlines and as an instructor. However, unlike most of the combatants, Colonel Sharman did not stop fighting on 11 November 1918, as he had been deployed in 1917 to Northern Russia, to command a brigade there against the Bolshevik forces. Colonel Sharman did eventually return to Canada in June 1919, and appears to have re-entered the civil service, but it is unclear in what capacity.¹³¹ Again, while Morrison's, and therefore Carstairs', claims about Sharman's leadership in narcotic control are clearly erroneous, there still remains the possibility that he was working in the civil service and made the recommendation to criminalize cannabis in 1923.¹³² This possibility is particularly worthy of consideration because his record indicates that he worked in both law enforcement and the civil service prior to the war, and thus would have been a good candidate for working in narcotic control after his return in 1919. Nevertheless, the theory that cannabis was criminalized due to international influences appears to be resting on increasingly shaky ground: the international community was largely unconcerned by cannabis

¹³¹ Royal Canadian Artillery Museum, “Col CHL Sharman CMG, CBE, ISO (1881-1970),” The Royal Canadian Artillery Museum, <http://en.rcamuseum.com/great-gunned/col-chl-sharman-cmg-cbe-iso-1881-1970> (accessed 21 January 2018).

¹³² Library and Archives Canada likely holds valuable information on Sharman in this file, but it is not digitized; moreover, according to the “Additional Information” section in the online description, the records on Sharman from 1914-1939 “may be mould contaminated.” Library and Archives Canada, Sharman, Charles Henry – Col., RG24-C-1-a, Box 94, File 5078-1. At the time of the defense of this paper, I am waiting to hear more about the status of these records.

prior to its criminalization in Canada, and the claim that Sharman was responsible appears to have been at least partly falsified.

The greatest challenge to the international position, however, lies in the fact that by 1922, there is evidence that at least some of the drug policies that Henri Béland was presenting to Parliament were developed outside of the Opium and Narcotic Drugs Branch entirely, as a result of domestic pressures. In April 1922 Béland made a peculiar statement in the House of Commons. He said, “it has been my privilege to receive an important delegation from British Columbia... in connection with the suppression of this illicit traffic. The matter is receiving our most earnest and favourable consideration in so far as some amendment of this [the Opium and Narcotic Drugs Act] is concerned.”¹³³ Initially, I struggled to find a record of the contents of this meeting, but this was resolved by a *Daily Colonist* piece regarding members from B.C. travelling to Ottawa, published on 29 March 1922. A short paragraph described a delegation from British Columbia, “which will present to the federal Cabinet the case against Oriental immigration at an early date.”¹³⁴ One of the delegates mentioned, an MP for Vancouver South, was the same Leon J. Ladner quoted above, who espoused moral reformer sentiments in parliament in June 1922.

The Vancouver City Archives maintains a robust fond of Ladner’s documents, which I was able to access. In particular, he kept a sporadic diary, written in faintly legible handwriting, but the entry for the 30 March 1922 gave the details of his meeting with Henri Béland, the Minister of Health:

This has been an interesting day. All the B.C. members... went as a unit to Dr. Henri Béland minister of Health to present our request for a change in the law so that those

¹³³ HCD, 6 April 1922, 773.

¹³⁴ *Daily Colonist*, “Unite in Pressing Oriental Exclusion,” 29 March 1922. The microfilm did not show the page numbers of the paper. It is telling that the title and content of the piece connotes political unity against Asian immigration, despite the fact that the group’s explicit purpose, according to both Ladner and Béland, was to restrict the drug trade. This reinforces the conclusion that Asian immigrants and drug use were viewed as the same problem in the 1920s.

convicted of the illegal sale of drugs... would be imprisoned and perhaps lashed. In the case of the Chinese, we ask for their deportation.¹³⁵

This immediately reiterates how politicians had accepted and reproduced the rhetoric of moral reformers regarding the link between Asian immigrants and drug use, but the diary also shows the steps Ladner took to gather the support of his associates. He goes on to point out that initially, some of his fellow British Columbians had been skeptical about the need for these measures. H.H. Stevens, who had chaired a committee which had amended the Opium and Narcotic Drugs Act the year prior, was an ex-cabinet minister and a strong debater, held “quite a bit of weight” in the delegation.¹³⁶ Having been responsible for the Act as it currently stood, Stevens “naturally defended the present law,” but Ladner was able to outmanoeuvre Stevens. He did this by calling a meeting of the delegates from B.C., in which he “calculated... to put the question from a new angle, so that the opponents... would find it very awkward. They would not want to see the others go back to B.C. and *face public opinion.*”¹³⁷ Ladner was able to rally his associates, including the superior debater and more senior party member H.H. Stevens, by relying upon the public demand for harsh measures against drugs and Asian traffickers that had been generated by moral reformers.

Ladner next produced eight stories for his associates in order to further convince them. While he spares his diary the details, they were about “girls 16 and 17 years old” who “had become addicts and sunk to the lowest depths of morality, prostituting with Chinese, Hindus, and Japs.” He then asked “if there was a man present who, after listening to those cases and realizing that this is somebody else’s little girl... would dare oppose a gaol sentence to every fiend who

¹³⁵ Vancouver City Archives (hereafter VAC), Leon Ladner Fonds, Series S8, Box 570-E-05, File 27, Trip- Ottawa, 30 March 1922.

¹³⁶ Ibid.

¹³⁷ Ibid. Emphasis added.

engaged in this iniquitous traffic.”¹³⁸ Having convinced his fellow delegates from B.C., they went “to ask the minister [Béland] for this change in the law in order to gaol and lash every beast convicted of illegal sale.”¹³⁹ Ladner outlined the issue for Béland, and once he “had the minister thoroughly convinced,” the Minister said, ‘can there be any reason to object to this amendment?’ All agreed there was none.”¹⁴⁰ Six weeks later, in May of that year, H.H. Stevens introduced the matter in the House of Commons for Béland. He first asked what proportion of the prosecutions for the sale of illicit drugs were against immigrants. Béland gave the figures, and in response, Stevens said “in the number of prosecutions a very large percentage were aliens. I believe that a very considerable portion of them were Orientals. In British Columbia... we have been asking that those found guilty and convicted in our courts shall wherever possible be deported.”¹⁴¹ Béland responded, “it can be readily understood that if Chinamen who indulge in the illicit trade in narcotics, especially opium, were deported, others would be deterred from taking a similar risk, and the trading would be very much restricted.”¹⁴² Subsequently, this policy would become law through an amendment to the Opium and Narcotic Drug Act.¹⁴³ Ladner and his associates had successfully “lobbied for increased penalties for traffickers.”¹⁴⁴ The manner in which Béland was convinced to support this legislation shows how amendments to this Act could be generated outside of the traditional bureaucratic structures of the Department of Health, as a result of domestic demand and the influence of the moral reform movement upon members of parliament. This is important, because it suggests that even if Carstairs is correct in saying that

¹³⁸ Ibid.

¹³⁹ Ibid.

¹⁴⁰ Ibid.

¹⁴¹ HCD, 19 May 1922, 2018.

¹⁴² Ibid., 2022.

¹⁴³ Canada, 14th Parliament, 1st Session (1922), *Annual Statutes*, 141.

¹⁴⁴ Roy, *The Oriental Question*, 61.

Emily Murphy's work was discounted by officials within the Opium and Narcotic Drug Branch, the work of moral reformers clearly impacted drug policy from outside of the branch's bureaucracy.

Conclusion

The reason for the criminalization of cannabis is unclear because of the absence of any psychotropic use of it in Canada at the time, and the relative lack of attention that the anti-drug campaign paid to it. The current explanation, seen in the work of Carstairs and Giffen, suggests that diplomats, who had returned from international duties where they heard of the risk of cannabis, reported this information to the Officer in Charge of the Narcotic Control Branch, F.W. Cowan. However, it now appears that there was very little international pressure, if any, to criminalize prior to the passing of Canada's legislation, and the role of Colonel Sharman is doubtful at best. Additionally, this explanation does not address the Canadian government's failure to justify, or even debate, criminalizing cannabis. The evolution of ideas about addiction emphasized the moral impact of drug use, which allowed drugs and their users to be vilified as social threat during the 1920s. This construction of addiction simultaneously deflected blame from doctors for iatrogenic addiction and legitimized their authority to regulate such "dangerous drugs," but it also proved fertile rhetorical ground for the agenda of the moral reform movement. Moral reformers emphasized the degenerative effects that drugs would have on Canadian racial purity and morality by arguing that drug addiction resulted primarily in a loss of the addict's self-control. These arguments also blurred the distinctions between intoxicating drugs, which would have permitted the association to be made between cannabis and the drugs more commonly targeted by the moral reform movement. What remains to be discovered is a documentary record of that association actually being made. Nevertheless, the moral reform movement was

extremely successful in generating public concern about drugs and demanded a response from parliamentarians.

Politicians were highly cognizant of these demands and, as a result, supported more restrictive drug policies. They had long been convinced of the dangers of intoxicants, and thus felt no need to interrogate the necessity of restrictions against them. Drugs were de facto threats to the self-control of individuals, and hence the morality and racial integrity of the nation. This helps to address the second failure of the Canadian government: its lack of investigation into the available knowledge on cannabis, such as the IHDC and the work of O'Shaughnessy and other doctors who supported cannabis therapeutically. By the 1920s, politicians needed no justification, and policy could be influenced by a motivated group of politicians, such as the B.C. delegation. This suggests the ease with which a similar conversation, in which a politician or bureaucrat espoused the “New Menace” of cannabis to Béland, could have resulted in its addition to the schedule. While I am unwilling to discount entirely the possibility that the desire to criminalize cannabis originated at international meetings, these insights suggest that, at the very least, a thorough re-evaluation of the domestic moral reformer literature and its connections to parliament is deserved. Regardless of the particulars of how cannabis was added to the schedule, it seems obvious that the long-term trends in addiction theory and the contemporary domestic political and social context provided the political weight and climate for criminalization to occur.

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