Prior to 1916, there were no restrictions on the possession and use of cocaine, opium and other psychoactive
drugs in Britain; the Poisons and Pharmacy Act of 1908 stipulated only that pharmacists had to have been
introduced to prospective buyers by someone known to them, and must record their names and addresses in a
poisons register.[1]

Nevertheless, the ease with which narcotics could be purchased before the war does not seem to have been
widely abused. At the end of the nineteenth century, drug addiction and related social problems affected only a
tiny proportion of the population, largely confined in the popular imagination to Chinese-run Opium Dens or
harmless eccentrics in the mould of Sherlock Holmes. Such calls as there were for the control of the narcotics
trade arose not from its consequences in Britain, but from Britain's role as a major hub in the drugs trade to
India and China, where the baneful effects of the commerce were far more obvious. [2]

The British authorities were largely ambivalent; the government of colonial India once relied on the sale of
opium to China for much of its revenue, and had only agreed to phase out the trade in 1907. The Indian Army
actually supplied its addicted troops with opium: in 1914, the Director of Supplies of the British Expeditionary
Force was informed he had to supply a daily ration of the drug (euphemistically termed 'Indian treacle?) to
6,000 Sikhs newly landed in France.[3]

In the absence of a National Health Service, the general populous was free to dose itself. On the outbreak of
war, many retailers saw an opportunity to sell medical kits to soldiers proceeding on active service (advertised
under such rubrics as 'a useful present for friends at the front?[4]), and some of these included cocaine or opium
for pain relief. As one commentator was quick to point out, 'unfortunately, men have in many instances been
tempted to take the tablets, not to diminish pain, but to act as a stimulant after fatigue.'[5]

Somewhat dubious anecdotal evidence suggested that the instance of 'morphia-habit' developed from such kits
was becoming serious. Existing legislation, however, prevented the authorities from banning the trade, and
vendors could only be prevented from selling dangerous drugs to soldiers on the grounds that they did so
without keeping records appropriate for the sale of poisons. Harrods was fined 5 for this offence in February
1916. As the prosecution noted, 'it was an exceedingly dangerous thing for a drug like morphine to be in the
hands of men on active service who knew nothing about medicine. It might have the effect of making them
sleep on duty or other very serious results.'[6]

In early 1916, a moral panic was whipped up by the press over the sale of narcotics to the troops. A widely-
publicised trial lead to the conviction of Horace Dennis Kingsley and Rose Edwards for selling cocaine on three
separate occasions to Canadian troops in Folkestone; during the trial, it emerged that 40 men in a local camp
had developed a drug habit. It is hard, however, to assess the overall severity of the problem facing the armed
forces; in a detailed analysis of 1,043,653 casualties admitted to Medical Units from 1916 to 1920 (admittedly after controls on drugs had been put in place), alcoholism accounted for 241 cases, while 'other poisons and intoxications' caused a further 794 admissions. It is likely that the latter total mainly represents the involuntary ingestion of harmful substances on active service: heavy metals entered food and water supplies; engines and stoves gave off Carbon Monoxide. The consequences of recreational drug use must have provided only a small fraction of these patients. The Official History of the Australian Medical Services dismissed drug addiction as a negligible problem, though did suggest that more research needed to be undertaken into the toxic effects of tobacco when smoked in 'stupendous' quantities!

If drug-use was not a pressing issue medically speaking, it was increasingly coming to be seen as a grave moral problem. In the Edwardian era, the public perception of drug use had subtly begun to shift. Drugs in fiction increasingly played the role of a corrupting influence: novels abounded in which naive young people were tempted to experiment and inevitably fell into drug-fuelled depravity. The string of newspaper stories in early 1916 fed upon such fears: the young recruit, unaware of the risks attendant on taking cocaine or morphine, might unwittingly render themselves unfit for active service and soon develop the most evil habits. Apparent links between cocaine use and prostitution added to the mounting moral concern: the detail that German scientists were the first to isolate cocaine and market it in the United Kingdom was frequently noted, playing on paranoid fears of enemy subversion.

On 8th August 1914, the government had introduced the Defence of the Realm Act (DORA), allowing the executive to create criminal offences through regulation. On 11th May 1916, the Army Council used these powers to enact regulation 40B, which banned the sale of cocaine, opium, Indian Hemp (cannabis) and other psychoactive drugs to troops without a prescription. The very same day, however, a trial sensationally collapsed in which a Mr Johnson, known to be supplying cocaine to soldiers via prostitutes, could not be convicted under the terms of existing legislation — a fact strongly condemned by the presiding magistrate. Calls for controls on the civilian possession of narcotics mounted, to which pre-war campaigners for the suppression of the international opium trade leant their influential support. On 28th July 1916, the provisions of DORA 40B were widened to criminalise the possession of cocaine and opium by anyone not connected with the medical or veterinary professions, and stipulated that the drugs could only be dispensed to patients (whether military or civilian) on exhibition of a non-reusable prescription signed by their doctors.

The subsequent history of DORA 40B again suggests the threat posed by drug-taking in the armed forces had been grossly over-estimated. Prosecutions under the regulation were few and far between, most falling on Chinese opium addicts. One of the unintended consequences of tightening controls was to restrict working-class access to dental anaesthetic: large numbers of unregistered dentists practised among poor communities in the North of England, and were suddenly unable to access their favoured pain-relieving drug — cocaine — legally. The findings of the subsequent Select Committee on the Use of Cocaine in Dentistry gave the lie to the regulators' justification:

*We are unanimously of opinion that there is no evidence of any kind to show that there is any serious, or, perhaps, even noticeable prevalence of the cocaine habit amongst the civilian or military population of Great Britain. There have been a certain number of cases amongst the oversea [sic] troops quartered in, or passing through, the United Kingdom, but there is hardly any trace of the practice having spread to British troop, and, apart from a small number of broken-down medical men, there is only very slight evidence of its existence amongst the general population.*

Reflexive criminalisation in reaction to a wartime panic had led to the first effective controls on narcotics in Britain; the subsequent Dangerous Drugs Act of 1920 retained most of the provisions of DORA 40B, but was more broadly aimed at bringing Britain into line with restrictions on the international opium trade demanded by the Versailles peace conference. This act served as the basis for all subsequent legislation, including the
current Misuse of Drugs Act of 1971. When drug addiction did become a substantive problem in the 1960s-1970s, criminal legislation was the solution suggested by precedents originally established in 1916; whether this was the most appropriate response to the new panic, however, lies outside the scope of this article.


